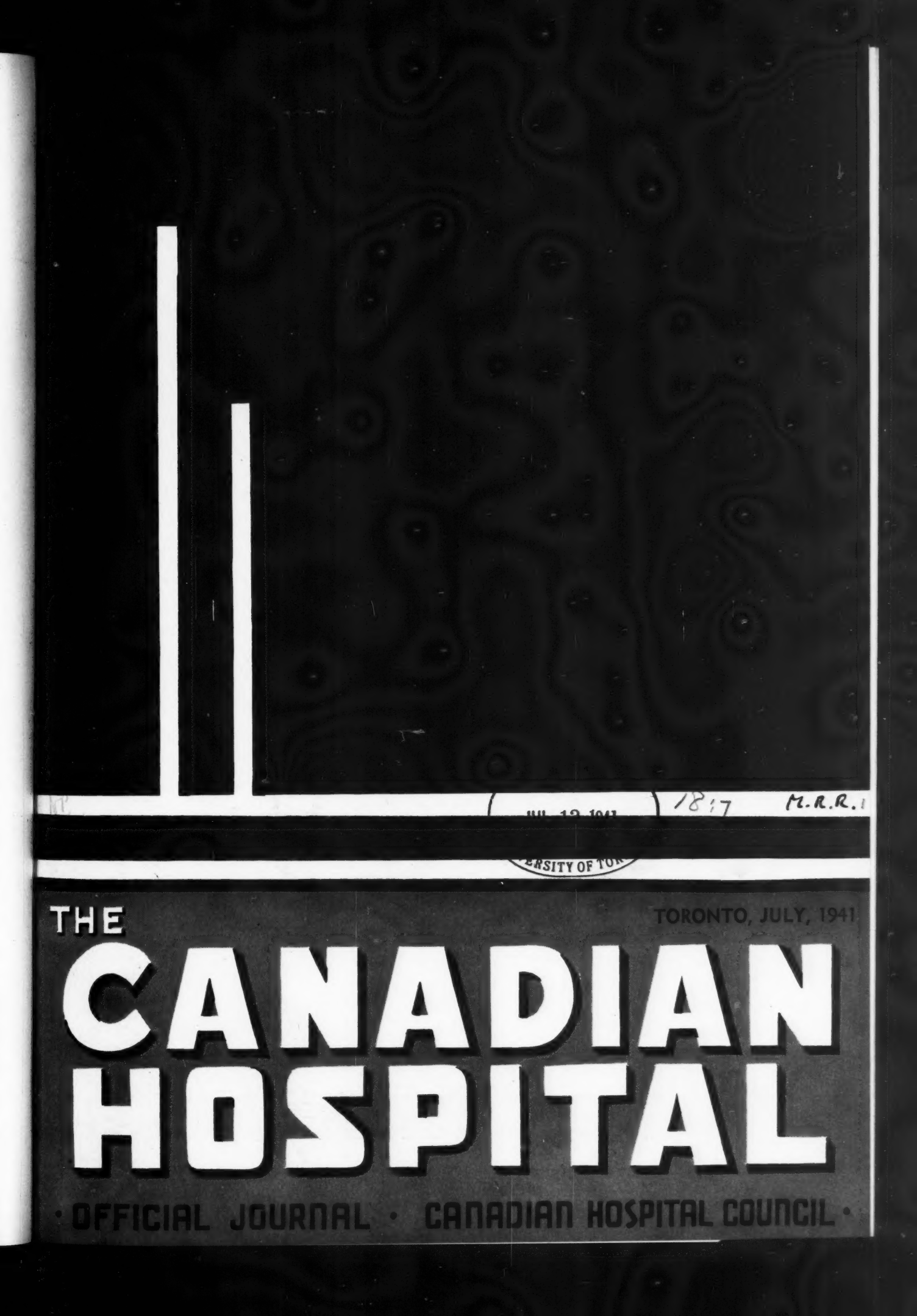



TORONTO, JULY, 1941

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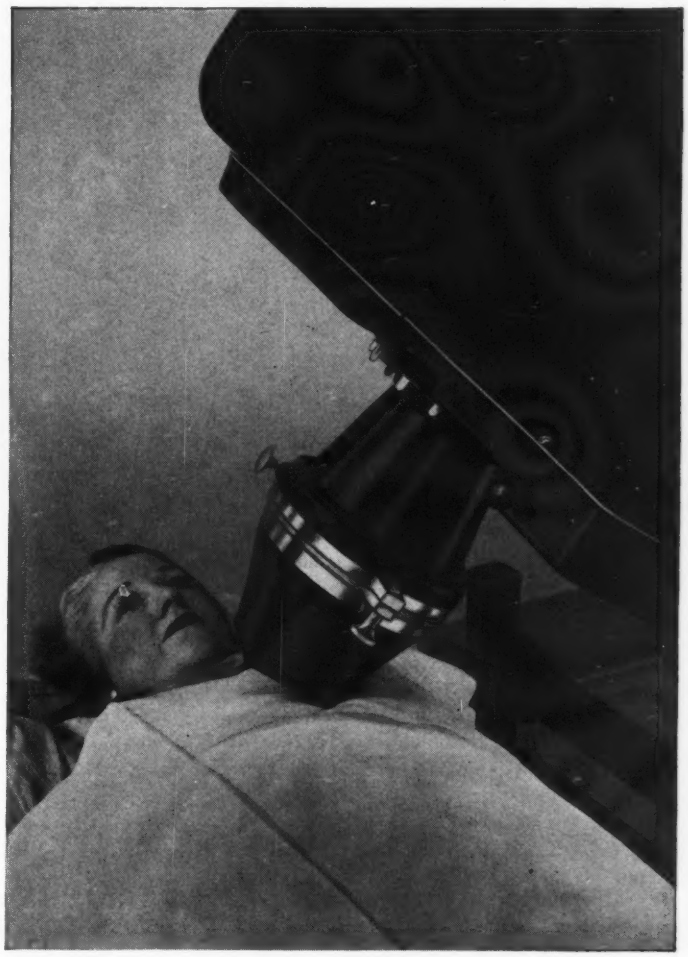

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# "The Canadian Hospital"

**Official Journal of the**

**Canadian Hospital Council**

Vol. 18 JULY, 1941 No. 7


## CONTENTS




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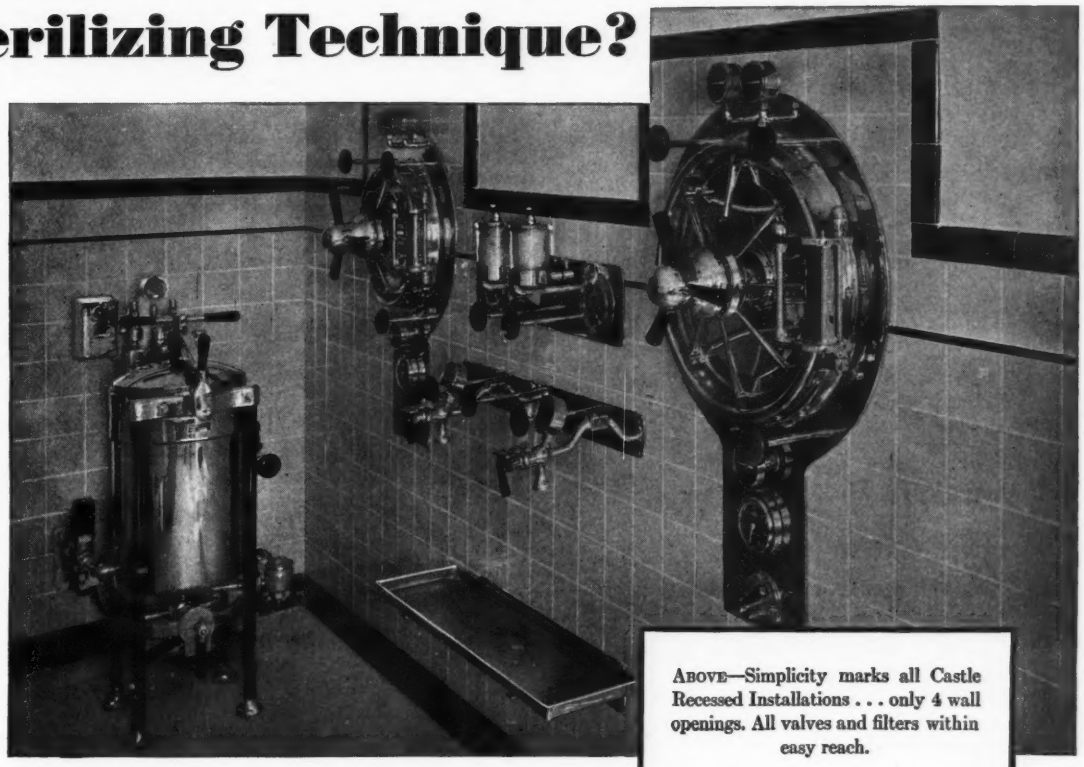

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Figure 1 and figure 2 from "The Sterilization of Dressings and Dry Goods" —Surgery, Gynecology and Obstetrics—November, 1940, Vol. 71.

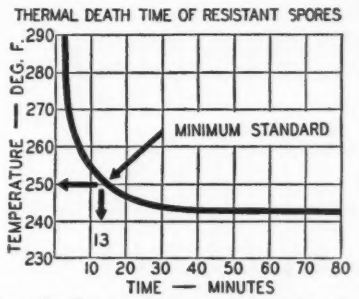


FIG. 1. Based on actual steam penetration, raising the temperature markedly decreases the exposure required.

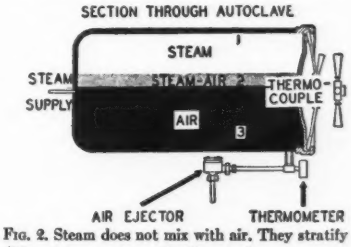


FIG. 2. Steam does not mix with air. They stratify at different temperatures. Castle autoclaves evacuate all air for complete safety.

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# ADVANCES IN CANNING TECHNOLOGY

## II. Development of the Tin Container

● Appert, discoverer of canning, did not know the reasons why his procedure for food preservation was successful. He clearly recognized, however, that his containers must be so constructed and sealed as to prevent contact of the food therein with air, after heat processing. Today we know that this is necessary to prevent reinfection of the food with air-borne, spoilage micro-organisms.

As containers, Appert suggested glass containers sealed by corks; the reason given is that glass is the "matter most impenetrable by air" (1). In 1810, one year after Appert's discovery was announced, Peter Durand, an Englishman, patented a procedure very similar to Appert's, which covered the use of a variety of containers, among them "vessels of tin (tin-plated iron)." From that time forward, the use of tin-plated containers rapidly progressed.

Commercial canning began in North America about 1819. In 1825, Kensett and Daggett, two pioneers of canning, received a United States patent covering the use of tin-plated containers. Shortly thereafter, the name "tin can" was coined from the abbreviation of the formal name, "tin canisters."

The story of the development of the tin can in North America is an absorbing one which has been related in more detail elsewhere (2, 3, 4). By the time of the war between the States, the "hole and cap" type of can had been evolved. About 1890, can-making machinery was introduced to replace the older hand-manufacturing operations whereby a skilled artisan could produce about 6 cans per hour. Modern can-manufacturing lines operate at speeds as high as 350 cans per minute.

The first three decades of the current century witnessed the development of machinery to make the modern type or "sanitary style" can now universally used for fruits, vegetables, and a wide variety of other products. The past ten years have brought vast improvements in the tin plate from which cans are made. Not long ago, almost any type of sheet steel was considered satisfactory. Today plate for cans must comply with rigid physical and chemical specifications established by the Research Laboratory of the can manufacturer.

As far as can be determined, tin containers were first introduced to avoid breakage which was experienced with the glass containers proposed by Appert. The other desirable characters of the tin container for foods were not fully appreciated at first; among these advantages should be mentioned its rapid rate of heat transfer, its low weight in relation to its capacity, and its opacity to light. Nor was the importance which the tin can has attained in our national life fully appreciated until world developments caused Canadians to pause and take inventory. Only then was it generally realized that from its humble start 130 years ago, the tin can has risen to become an indispensable article in our modern civilization.



(1) 1811. The Art of Preserving. M. Appert, Black, Parry and Kinsbury, London.

(2) 1937. The Canning Clan. E. C. May, The Macmillan Co., New York.

(3) 1937. Appertising. A. W. Bitting, The Trade Pressroom, San Francisco.

(4) 1940. The National Geographic Magazine, November, p. 659.

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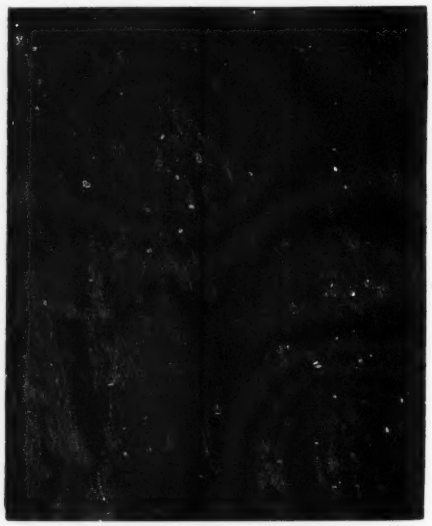

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The CANADIAN HOSPITAL

Toronto, July, 1941 Vol. 18 No. 7

# Limited Number of Courses Approved for Volunteer Nursing Aides

## Representatives of C.N.A. and C.H.C. Confer

IN AN effort to clarify the somewhat confused situation with respect to the provision of hospital training for volunteer nursing aides, a conference was held in Montreal on June the 2nd attended by representatives of the Canadian Nurses Association and the Canadian Hospital Council. The Canadian Nurses Association was represented by Miss Grace M. Fairley, Vancouver, President, Major Elizabeth Smellie, Ottawa, Vice-president and Matron-in-Chief, R.C.A.M.C., Miss Jean S. Wilson, Montreal, Executive Secretary, Miss Marion Lindeburgh, Montreal, 2nd Vice-president, and Miss A. J. MacMaster, Moncton, Honorary Treasurer. The Canadian Hospital Council was represented by Dr. George F. Stephens, Montreal, President, Miss K. W. Ellis, Saskatoon, Chairman, Committee on Nursing, and Dr. Harvey Agnew, Toronto, Secretary.

Others present were Miss Blanche Anderson, Ottawa, Chairman of the Hospital and School of Nursing Section of the C.N.A., Miss Eileen Flanagan, Montreal, Red Cross representative, and Miss Ethel Johns, Montreal, Editor of *The Canadian Nurse*.

The following points were brought out in the discussion:

No call for V.A.D. training has come from either Canadian or British military headquarters.

If the services of volunteer nurses be required, such will probably not be for overseas service but will be to nurse civilians in Canada. Such nursing will probably be as much home nursing as hospital nursing, if not more so. A study has been made of the number of inactive nurses who might be available for duty in case of an emergency at a distant point; this number is not large. Many of these retired nurses are prepared to serve but would prefer to do so in their own province. In case of an emergency in some part of Canada, V.A.D.'s would probably be more mobile than many of the inactive nurses. The amount of training which can be given to V.A.D.'s in a few weeks cannot fit them for very heavy nursing responsibilities. If this war is to be a long one, as it appears to be, there should be encouragement for girls to take the regular course.

### Experimental Courses

The following resolution was approved:

"Inasmuch as there may be a shortage of graduate nurses and inasmuch as in the future voluntary nursing aides for disaster and emergency service may be needed and inasmuch as there will be a number of problems to be solved in the organization of the necessary instruction for voluntary nursing aides,

"BE IT RESOLVED That this Joint Conference of the Canadian Hospital Council and the Canadian Nurses Association deem it advisable that selected hospitals set up *experimental courses* in voluntary nursing auxiliary training following a curriculum prepared by the Sub-committee on Syllabus of the Canadian Red Cross Society and the St. John Ambulance Association as may be revised by the Canadian Nurses Association."

### Other Courses Not Encouraged

The representatives of the Canadian Nurses Association have endorsed the following resolution:

"WHEREAS the Joint Meeting of the Canadian Hospital Council and the Canadian Nurses Association endorsed the plan for experimental courses for voluntary nursing auxiliaries, it is recommended that the Canadian Nurses Association recommend to the provincial associations of registered nurses that *other hospitals do not undertake* such courses until the results of the experimental courses be made known."

**Four Experimental Courses Recommended**

On resolution it was agreed that *"experimental centres* be set up in Halifax or Saint John; Montreal; Toronto; Victoria or Vancouver."

**Legal Liability**

It is realized that hospitals accepting volunteer nursing aides may face some medico-legal liability in case of an emergency. If the responsibilities be reduced commensurate with the experience in training of the volunteers, such danger should not be very great, but would exist nevertheless. Accordingly, it was agreed that a sub-committee of the Canadian Nurses Association should take over the syllabus of instruction for voluntary nursing auxiliaries and so revise this syllabus that the utmost medico-legal protection be given to the hospital. The committee nominated by the Canadian Nurses Association is made up of Miss Blanche Anderson, Convenor, Miss E. Frances Upton, Miss Martha Batson and Miss Alice Albert. The Matron-in-Chief, Miss Smellie, will act as an advisor to the committee.

The following points were brought out in the discussion:

In view of the uncertain demand for the services of V.A.D.'s, the courses should not disturb the present teaching and work of supervisors. It would be desirable that certain wards or services be set apart for the training of these volunteer workers and that their teaching be apart from that of the regular classes.

Volunteer aides should not be confused with regular ward aides or ward helpers.

Hospitals should not exploit volunteer workers.

The Red Cross representative assured the committee that those desiring to take these courses understood that they were not being trained for overseas service or to nurse soldiers, as far as is now known, but would be given this instruction with the expectation that they would be prepared to nurse civilians wherever the emergency would arise in Canada.

It was agreed that the Red Cross Society and the St. John Ambulance Association should be asked to explain to volunteers the necessity of working with qualified nurses. It is understood that the instruction would be given largely by instructors supplied to supplement the hospital staff. This would probably be arranged without cost to the hospital.

# Emergency and Disaster Preparations at the Royal Victoria Hospital, Montreal

***GEORGE F. STEPHENS, M.D.***
***Superintendent***

A SURVEY has been made in the hospital to find out what emergency bed accommodation can be made (1) immediately ready or (2) on short notice or after a longer period of preparation.

1. *First Emergencies*

Extra beds in present ward, the patients being under ward care and utilizing ward supplies. The number of these is recorded.

The location of these extra beds and mattresses.

2. *Second Emergencies*

Head nurses each day review their patient population and know what patients can immediately be gotten out of their beds, either to sit in a chair or lie on a mattress on the floor until other accommodation may be arranged for them.

Extra medical and surgical supplies are kept available for immediate use.

3. *Subsequent Emergencies*

All conveniently usable hospital areas are recorded as also the number of bed spaces where beds or mattresses could be quickly placed, together with the information as to where beds and mattresses are stored.

Reserve stocks of blankets and linen ready for immediate use, reserve dressings, equipment, such as sprays for burns, hot water bottles, etc.; narcotic and resuscitation drugs are kept adjacent under lock and key. Oxygen and carbon dioxide (kept under constant inspection), splints, etc., will be kept available.

*Medical Service*

It is anticipated that this will be available without any special arrangements except during summer week-ends when special schedules may be necessary.

*Nursing Service*

There is to be kept a record of the number of nurses who can be released from other duties and made available for the first and second line of emergencies. A reserve list will be maintained of nurses on call whose services may be secured with only a short delay.

*Blood Bank*

This is being built up so that serum at least will be available and a reasonable supply of blood.

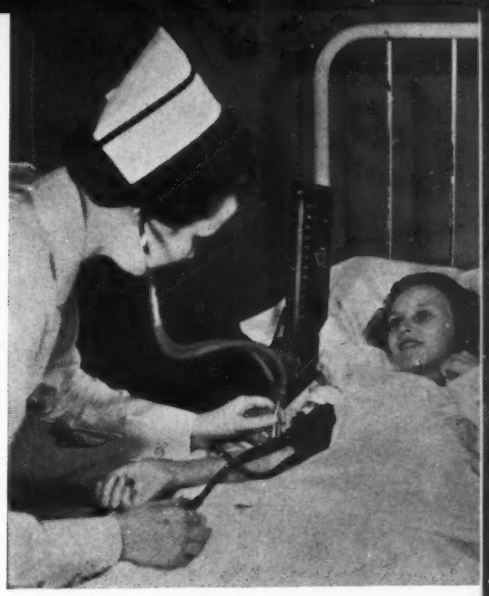
*A.R.P.*

Thought has been given but no action taken in respect to A.R.P. arrangements:

1. On the assumption that fire will be the main hazard and gas not likely used, no decontamination chamber has yet been arranged.
2. Bomb proof shelters would not serve any great purpose unless the hospital could be previously evacuated and this only retained for staff and emergency patients.
3. No alternative has yet been secured in case of interruption of water service, light and power (except the ordinary portable units) and gas.
4. "Black outs" have not been done.

**Calling all hospital workers! Remember the sixth biennial meeting of the Canadian Hospital Council is being held in the Windsor Hotel, Montreal. The meeting will begin the afternoon of September 10th and continue through the 11th which gives plenty of leeway to those who are Atlantic City bound for the A.H.A. convention September 15th to 19th.**

# Assumption of Clinical Duties by Nurses Given Further Recognition



*Blood pressure reading at the Regina Gene*

AT the joint conference of representatives of the Canadian Nurses Association and the Canadian Hospital Council in Montreal on June the 2nd, described in the previous article, there was considerable discussion on the extent to which specially selected nurses, in the absence of interns, should undertake certain clinical duties. The increasing shortage of interns, partly due to the increasing normal shortage and now augmented by the war situation, has made this subject a pertinent one in too many hospitals. During the past year the situation has become so vital in many hospitals that it was felt that former discussions of this subject by both organizations should be crystallized in a resolution which should be approved by both bodies.

This discussion was materially aided by data obtained by Miss K. W. Ellis of Saskatoon, chairman of the Canadian Hospital Council Committee on Nursing. The discussion elicited the following points:

There was general agreement that there is considerable need for more clinical assistance, particularly in view of changing clinical procedures as, for instance, continuous intravenous injections. It is a common practice in an increasing number of hospitals to have selected nurses perform various clinical duties. Medical staffs in many parts of the country are urging the administration to authorize such procedures.

Some hospitals are hesitant to assign responsibilities to even selected graduate nurses because of the potential legal difficulties in case of accident.

Such legal possibilities would be considerably reduced if it could be shown that the hospital was following a recognized procedure.

The accompanying resolution was passed by the joint conference and was later ratified by the full executive of the Canadian Nurses Association:

**Assignment of Certain Clinical Procedures to Selected Graduate Nurses**

"WHEREAS the changing nature of hospital practice has necessitated the greater use of clinical and technical procedures in the treatment of various conditions and

"WHEREAS over 90 per cent of our hospitals do not have interns and many of those normally employing interns are having increasing difficulty in obtaining an adequate number of interns,

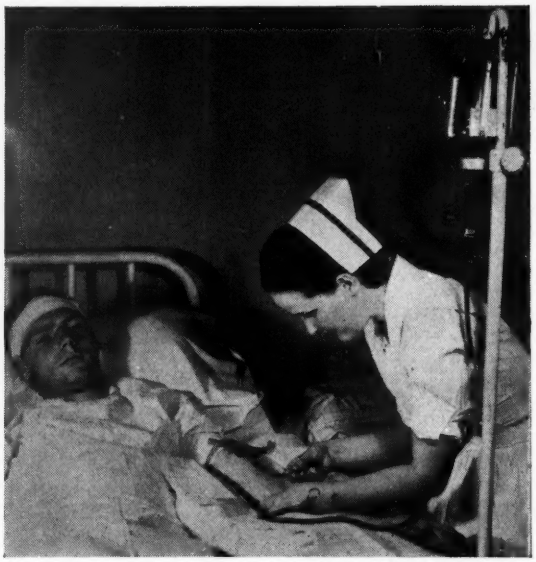
"THEREFORE, BE IT RESOLVED, That this Joint Conference of representatives of the Canadian Nurses Association and the Canadian Hospital Council, convened to discuss this question reaffirms the principle already endorsed by the Canadian Hospital Council and by the Nursing Education Committee of the Canadian Nurses Association, to wit, that in those hospitals unable to obtain adequate intern service, it should be considered sound procedure for hospitals to permit the following to be performed by nurses, provided such be done by one or more graduate registered nurses on the hospital staff carefully selected and trained for this work:

Blood pressure readings;
Subcutaneous injections;
Intravenous injection of saline and glucose solutions and such other medications or diagnostic fluids as the medical staff may authorize;
Taking of Wassermans;
Removal of sutures;
Intra-muscular injection of substances specifically authorized by the medical staff;
Recording of histories (with the exception of the physical examination)
Progress notes as dictated by the physician in charge;
Such other clinical procedures as may be recommended by the medical staff and approved by the director of nursing and the board of trustees.

"FURTHERMORE, BE IT RESOLVED, That before instituting any part or all of the above outlined arrangement, such be approved by the organized medical staff, by the director of nursing and the governing body of the hospital."

#### Increased Staff If Necessary

It was emphasized that the assignment of clinical duties, particularly time-consuming ones, such as the writing of clinical histories or the watching of continuous intravenous injections would in many cases place an added burden upon the nursing staff and that such allocation of duties might require an additional member to the graduate staff. If the duties undertaken by a selected graduate nurse would not require her full time, such duties could be combined with such other duties as her time-table would permit. A nursing staff already working to full capacity should not be asked to undertake additional responsibilities without making the necessary additions to the staff.



*An intravenous being given by a specially trained graduate nurse at the Regina General Hospital.*

*Photos courtesy Regina General Hospital.*

# Control of Surgery in Hospitals Discussed

Several topics of interest to hospitals were considered at the Winnipeg meeting of the Joint Relations Council on Medical Education, Hospitals and Licensure, an informal gathering of representatives of the medical schools, the licensing bodies, the medical associations, the Canadian Hospital Council, the R. C. P. S. of Canada and other bodies which takes place each year at the time of the C. M. A. convention. Dr. F. J. H. Campbell, Dean of Medicine at the University of Western Ontario, presided.

The control of surgery in the less well equipped and organized hospitals was a major subject. The Faculty of Medicine of the University of Montreal forwarded a resolution to the effect that hospitals receiving provincial grants should require all *new* doctors desiring to do surgery to have a diploma in medicine or surgery granted by the R. C. P. S. (C) or to have a diploma in his specialty granted by a faculty of medicine. This was debated in principle. Various speakers, while agreeing that too much non-emergent surgery was being done in inadequately equipped and staffed hospitals, felt that it was premature to support this requirement. Dr. F. S. Patch of McGill held that education of the public to demand that surgeons be qualified was most essential. Hospital trustees, too, should not condone the doing of non-emergent surgery by other than qualified surgeons. Pointing out that this was a country of great distances, Dr. R. I. Harris of Toronto stated that it was not always easy to obtain a qualified surgeon. One of the big problems of to-day is to provide good surgeons for rural areas. Dr. Otto Niemeier of Hamilton urged affiliation between small and large hospitals. He suggested that the public be made more discriminating by reserving the term "hospital" to those institutions meeting certain requirements. Dr. Fulton Gillespie of the University of Alberta urged more graduate facilities for the training of surgeons.

It was announced that the Royal College of Physicians and Surgeons of Canada is now developing a plan for the issuance of certificates in six specialties.

#### The War and the Students

Assistant-Dean E. S. Ryerson reviewed the recent conference respecting the speeding up of the medical courses. He pointed out that speeding up is necessary and that internships must conform to the graduating dates. Financing is not a major problem if a student loan system be set up by the government or other body. Several provincial registrars assured the colleges that they would endeavour to meet the new conditions thus created. Dean A. T. Mathers of Manitoba pointed out that in Manitoba 75 per cent of the medical students earn their way in whole or in part. Courses cannot be speeded up unless the students receive financial help. Professor V. E. Henderson, (Toronto) suggested that, as the actual cash outlay of the medical school would not equal the normal fees, the balance be loaned back at 3 per cent. A resolution was carried proposing that the Dominion loan to medical students at three per cent interest sufficient funds to meet the annual fees and to cover subsistence up to sixty dollars a month.

#### National Licensure

A resolution previously passed by the College of Physicians and Surgeons of Manitoba proposing that the present system of provincial licensure be replaced by a national one under the Medical Council of Canada was discussed by a number of provincial registrars. Dr. W. G. Campbell of Manitoba strongly supported the proposal but registrars from several provinces were of the opinion that the present method of provincial registration and licensure had sufficient advantages to warrant its retention.

# FIFTY YEARS OF GROWTH

## Holy Cross at Calgary Celebrates Golden Anniversary

*By SALLY LUNNEY*
*Calgary*

EARLY in the New Year of 1891 the Grey Nuns came to Calgary to operate the hospital which was then under construction. The pioneer Sisters walked in the darkness from the station to the Sacred Heart Convent where they were to stay until the hospital was completed. When daylight arrived they found the new building of which they were so proud. It was equipped to provide shelter and care for the sick but possessed only four beds for patients.

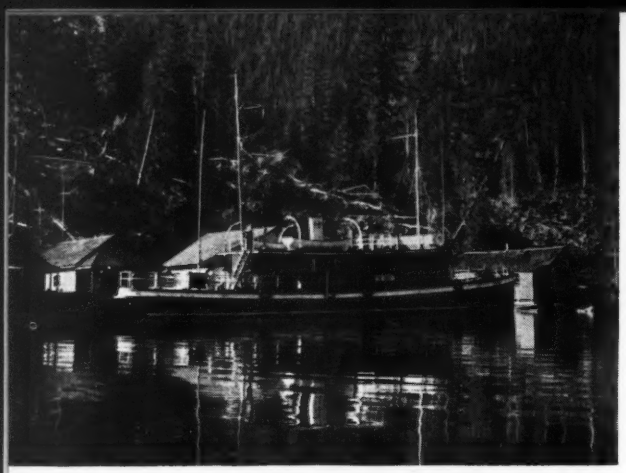
Before leaving the east the Sisters had received some money from St. Patrick's Church in Montreal which they used for equipment for the institution and on April 10th, 1891, their first patient was admitted. On May 3rd, of this year, when the fiftieth anniversary of the institution was celebrated, the same first patient, having recovered from his attack of typhoid and weathered the storms of western Canada until the present time, was present as an honoured guest. Incidentally, he is still in a very good state of health.

The name and fame of the new hospital was not long in spreading and by December 31st, 1891, 64 patients had been admitted. The little 4-bed building had already proven too small and plans had been undertaken for a new structure. The financing of a hospital was as difficult then as now and the plans for the new building were of a very imposing nature, the sum of $6,000 having been appropriated for the building, with an additional sum of

*(Continued on page 44)*

*Above—*
*Original Hospital, 1891.*

*Left—*
*Present Hospital, 1941.*



# A SEA-GOING MEDICAL SERVICE

## As Described by One of the Doctors

*H. S. HAMILTON, M.D.*
*Surgeon, Hospital Ship "Columbia"*
*Alert Bay, B.C.*

THE Columbia Coast Mission has operated on the Pacific Coast since 1905. It was founded by the Rev. John Antle following a survey of the Coast which he made in a small boat in 1904. A beginning was made with one hospital at Rock Bay, one doctor and two nurses, one clergyman and one secretary-treasurer. With the expansion of the logging and fishing industries on the Coast its growth has been steady and rapid, until to-day its services reach out and cover 20,000 square miles of land and sea between the northern half of Vancouver Island and the opposite mainland. To serve this territory there are at present three hospitals, two hospital ships, one mission ship and a staff of 48 which includes 5 doctors, 13 nurses, 2 clergymen, 2 school teachers, 4 office staff and 22 employees in the hospitals and on the ships.

### The "Columbia"

With this as a background let us take a closer look at the hospital ship, "Columbia", with whose ups and downs in a literal sense I have been associated for the past year. She is a wooden vessel of 164 gross tons, 100 feet in length with an 18 foot beam, and carries a crew of 5, including clergyman and doctor. An average speed of 10½ knots is maintained depending on wind and tide. The ship has a number of unique features including radio-telephone, well equipped surgery with full medicine shelves, a lending library with a seemingly inexhaustible supply of magazines of all kinds and modern 16 mm. talking picture equipment. A small organ and a folding altar are carried in the main saloon. A three-fold service, spiritual, social and medical is thus rendered to the approximately 4,000 people in the Columbia's district, which is roughly the northern half of the above mentioned area.

### Medical Service

The chief industries on this section of the Coast are logging and fishing, and it is to these logging camps of varying sizes, fishing stations, canneries and a few villages that the "Columbia" brings a glimpse of the outside world. In the course of a month's patrol we travel approximately 1,200 miles, making monthly calls at the smaller camps and attempting to visit the larger and more isolated ones every two weeks. This schedule is often interrupted and disorganized due to emergency calls, as many as three having been received in two days. The government wireless station at Alert Bay is contacted every hour to receive calls from the hospital there, or messages which have been relayed to us through that station. Broadcasts from the ship at 10 a.m. and 4 p.m. indicating her position are easily picked up on home radio sets within a radius of 60 to 100 miles.

The medical work done resembles that encountered in general practice with two or three obvious differences. Instead of dashing down the highway in an automobile we jog along at 10½ knots up long winding fjords, often edged with snow-capped peaks, or through narrow channels between densely wooded islands of all sizes and shapes. Due to the nature of transportation and distances involved, patients cannot always be seen as often as might be desired, and if any doubt exists regarding a favourable prognosis at home they are taken to hospital. Many minor accidents and diseases are treated on board and in the home, but the more serious cases are hospitalized. During 1940, 965 patients were treated, 562 on board and 403 ashore.

### Emergency Calls

An emergency call, whenever received, demands attention. Receiving and responding to these messages constitute possibly the most dramatic part of our work. I well remember one instance which occurred in the early spring when weather conditions are anything but settled. We had just tied up at a small settlement in a sheltered bay early one afternoon, after an hour's buffeting by a strong south-east wind and a rough sea. I was preparing to go ashore to make some calls when the radio crackled out an urgent request to go to a camp some 50 miles distant as soon as possible. Suspecting that this was a ruptured duodenal ulcer case, we set out at once after making everything fast that could move. The usual 1¼ hour trip across Queen Charlotte Straits took us twice that long in the teeth of the wind and rising sea. However, we finally

arrived safely and got the patient to hospital that night.

A question that is often asked is: "Have any babies ever been born on the 'Columbia'?" To the best of my knowledge the answer is "no", although there have been several very close calls while rushing the patients to hospital. Most maternity patients plan on going to one or other of the hospitals at the various locations for their confinements, but occasionally a premature arrival upsets even the best ordered plans. On one occasion we made a run of 80 miles in response to such a call but came in a poor second in our race with the stork. On our arrival, however, mother and daughter were both doing well.

#### Work Among the Indians

Another picturesque aspect of our work is visiting the various Indian villages in our territory and caring for the sick among them. These simple people have no words for "bacteria" or "germs" in their language and find it hard to understand even the basic principles of health and disease. Their old superstitions, however, are gradually giving way to a more rational approach to the study of health chiefly through the education of the younger generation in the government Indian schools.

Many of the villages consist of a cluster of houses fringing a grassy bank, which in turn is usually fronted by a beach strewn with clam shells. As the "Columbia" approaches, blows her whistle and anchors, boats of all descriptions, including dug-out canoes, rowboats, gas-boats, and others not easily classified, put out from the shore. Many different lesions and diseases are seen but, as one might expect from the prevailing sanitary conditions, skin diseases are common. Dental decay is extremely prevalent and many Indians have parted with several teeth aboard the "Columbia".

#### Death-Bed of a Chief

Occasionally a trip ashore is necessary to see some bed-ridden patient. Such an incident occurred several months ago. Shortly after we had dropped anchor at a small settlement near the north end of Vancouver Island late one afternoon an emergency call came over the radio asking us to go to see one of the district Chiefs who was very ill at a village about 40 miles distant. The engine purred, the anchor was hoisted and we were soon on our way. Four hours later, as we approached the village in the gathering darkness, a lighted lantern at each end of the crescent-shaped beach could be seen through the gloom. After anchoring off-shore a little way, I was paddled to the beach in an unsteady dug-out canoe and led to see the sick Chief. He was lying on a pile of blankets in a corner of one of the large old community houses that one sees still standing in most of the villages today, surrounded by a group of squaws and children, with the men at the perimeter of the circle. The building was lighted by one or two lanterns and in the semi-darkness eerie shadows flickered on the boarded walls of the ancient structure.

A brief history was obtained through an interpreter and a short examination revealed almost total paralysis from a stroke. The Indians themselves, sensing that the end was near, rejected the offer of hospitalization preferring to have their old Chief spend his last few hours amongst his own people. As we drew away to a safer anchorage for the night, the lanterns on the beach grew dim and finally flickered out, seeming to anticipate the fate of the old Chief who was gathered to his fore-fathers a few hours later.

Besides the medical work one or two other aspects of our day to day routine should be mentioned. Informal church services are conducted from time to time on board, and occasionally marriages are solemnized and christenings held. Educational pictures, news reels, comics and from time to time a feature length picture are shown on board in the evenings or in the dining hall in the larger camps. The official pictures of Canada's war effort are also shown as often as available. Magazines are distributed and books loaned to all who care to read.

In this way the "Columbia" brings medical aid, spiritual minsitrations and not a little diversion to those people in its territory who, by reason of their occupation, are isolated from the outside world in logging camps, lighthouses, fishing stations and in other remote sections of the Coast.

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## Prairie Provinces Conference, C.H.A., Holds Convention

The annual convention of the Prairie Provinces Conference of the Catholic Hospital Association was held at St. Boniface Hospital, St. Boniface, Manitoba, on June 25th and 26th. One of the outstanding addresses was that by Rt. Rev. Msgr. Maurice Griffin of Cleveland, First Vice-President of the C.H.A. on "Hospital Service Plans". Msgr. Griffin's long experience with the A.H.A. Commission on Hospital Service Plans made his remarks particularly authoritative. P. W. Dawson of the Manitoba Hospital Service Association described some of the features of the local plan. Dr. Harvey Agnew of Toronto differentiated between "health insurance" and "state medicine".

"The Moral Code in a Catholic Hospital" was considered by Rev. E. A. Reddin, S.J., of Winnipeg; "Catholic Action in Schools of Nursing" by Rev. A. D'Eschambault, D.D., D.C.L.; "Social Doctrine of the Church as applied to Hospitals" by Rev. M. Caron, S.J., Rector of St. Boniface College; and "Social Service" by Rev. Sister M. Crescentia of the Catholic Welfare Bureau, Regina. The President, Sister M. Beatrice of Lethbridge spoke on the "Advantages and Disadvantages of a Central Dietary Service". Rev. D. J. Mulcahey of Saskatoon spoke on "State Medicine in Saskatchewan".

Celebrant of Holy Mass at the opening session was Rt. Rev. Msgr. W. L. Jubinville, P.D., V.G. Dr. O. C. Trainor, pathologist and medical superintendent at Misericordia Hospital, Winnipeg, presided at this session. The committee in charge arranged a visit to the Grotto of Notre Dame de Lourdes and to the Occupational Therapy Exhibits at St. Vital Sanatorium, where Sister Anthony, Sister of St. Martha, spoke on occupational therapy. The attendance was very gratifying.

# Standard Nomenclature Approved for Hospital Use

## Report of Special Committee on Nomenclature of the C.M.A.

AT its Winnipeg meeting in June, the Executive Committee of the Canadian Medical Association approved a report on nomenclature by a special committee appointed last November. This report, submitted by its chairman, Dr. Harris McPhedran of Toronto, reads in part:

The great majority of our hospitals have no official nomenclature, even many of those employing trained record librarians, which failure makes the task of these librarians difficult by not having a uniform system of recording diagnoses and clinical findings. Those who have to do with clinical records in the hospital —the doctors, the nurses and the interns, use terms which reflect almost entirely their medical training and their more recent reading. As writers of textbooks have been slow in adopting a uniform terminology, the individual soon finds himself recording diagnoses in terms which may be drawn from several accepted systems. Frequently the best medical writers are found to use conflicting terms in the same article. Very few indeed of the medical schools make any effort to teach a uniform system of terminology, with the result that the student may pick up one set of terms from the pathologist and others from the clinicians. As the various interns, drawn from different schools, may record the same diagnoses in different ways, the record librarian is faced with a situation where the same condition may be indexed under several headings, thus making it virtually impossible to make proper use of the records for statistical, analytical or research purposes.

The desirability, and in fact the absolute necessity, of the adoption by our hospitals of some recognized system of nomenclature is obvious. It is encouraging to note that this is being done in an increasing number of hospitals. Unfortunately, for some years back there have been a number of more or less recognized systems of nomenclature, with the result that, while the recording of the clinical work in the individual hospitals has been improved, there still remains the difficulty of the broader analysis of data and the difficulty of comparing work done in one hospital with another.

### Systems Now in Use

Up until a few years ago the systems most commonly used in Canada and the United States, where hospitals had adopted some official system, were the "Bellevue" and the "Massachusetts General Hospital" nomenclatures. The "Lambert", "Mercur" and, in some hospitals, nomenclatures of their own development have been in use. A number of hospitals still use some of these systems. Within the last few years the "Alphabetical Index", developed by Dr. T. R. Ponton, formerly of Vancouver, has been widely adopted. There is also the "Nomenclature of Diseases of the Royal College of Physicians of London". This does not seem to have been very widely adopted in Canada.

The Royal Canadian Army Medical Corps and the Department of Pensions use for their special purposes the "Standard Morbidity Code for Canada", prepared a few years ago by the Department of Pensions and National Health in collaboration with the Dominion Bureau of Statistics. There is also the "International List of the Causes of Death" which is officially recognized for health statistics by the Federal Government.

In 1928 the Conference on Nomenclature of Disease, under the Chairmanship of Dr. Haven Emerson, was held in New York, at which time plans were laid by representatives of over twenty national medical, hospital and allied organizations to work out a system of nomenclature which could be generally adopted to overcome this confusion in nomenclature. With the financial help of the Commonwealth Fund and several insurance companies the "Standard Classified Nomenclature of Disease" was produced in 1933. Since that time this system has been very widely adopted by hospitals in Canada and the United States and was recommended for adoption, just prior to the war, by a committee representing a number of voluntary teaching hospitals in London.

### Adoption of Nomenclature Urged

It is recommended by the Committee that *all hospitals with organized medical staffs should adopt a recognized system of nomenclature of disease.*

It is further recommended that, if at all possible, *hospitals throughout Canada should adopt a uniform system of nomenclature* so that comparative analysis of clinical statistics and collection of data covering a large area would be possible.

*What system can be recommended for general adoption?* Two factors should influence this decision: com-

### Summary of Recommendations

**1. All hospitals with organized medical staffs should adopt some form of nomenclature.**

**2. If at all possible there should be general uniformity in the adoption of a nomenclature.**

**3. The nomenclature of choice for official recommendation would seem to be the "Standard Classified Nomenclature of Disease".**

parative excellence of the different systems and common usage. Fortunately the selection of a system was simplified last year. The two most widely used systems and the two that would seem to fully meet clinical requirements have been Dr. Ponton's Alphabetical Index and the Standard Classified Nomenclature of Disease. In March of 1940 Dr. Ponton announced the withdrawal of his system in favour of the Standard Classified, voluntarily making this gracious gesture in order to permit uniformity in clinical records. Other systems widely used in hospitals, such as the Bellevue, Massachusetts, Lambert, etc., are not as generally used now as formerly and, by many, are not considered as acceptable from the viewpoint of present day classifications. The Morbidity Code for Canada is an excellent nomenclature but does not permit as detailed classification as is desired for general hospital purposes. The same would apply to the International List of the Causes of Death upon which the Morbidity Code is based.

In view of the outstanding qualities of the Standard Classified Nomenclature of Disease, its wide and increasing usage by hospitals on this continent and elsewhere, and its adaptability for numerical indexing and for punch card use, your Committee recommends

THAT the Canadian Medical Association officially recommend the use of the "Standard Classified Nomenclature of Disease" in hospitals, clinics and elsewhere.

Official recommendation of the Standard Classified Nomenclature by the Canadian Hospital Council is being recommended to that body this year by its Committee on Nomenclature, a committee made up of medical men interested in clinical records and of record librarians. It is also officially endorsed by the American Hospital Association and the American College of Surgeons, both of which bodies are well represented in Canada. The Standard Classified Nomenclature is now officially sponsored and supported by the American Medical Association.

The summary of recommendations is as given herewith in the boxed insert.

The Committee on Nomenclature of the C.M.A. was composed of the following: Duncan Graham, O. C. Trainor, Frank S. Patch, Harvey Agnew, Harris McPhedran, (Chairman).

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**Military Hospital Opened at Debert**

A new 500-bed military hospital has been opened at Debert, Nova Scotia. The hospital is staffed by members of No. 7 Active Force of the R.C.A.M.C.

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**Edmonton Hospital to Build Addition**

The University of Alberta Hospital, Edmonton, is reported to be planning construction of a $60,000 addition. The addition is to be used by the Department of Pensions and National Health in dealing with returned soldiers and for administrative purposes.

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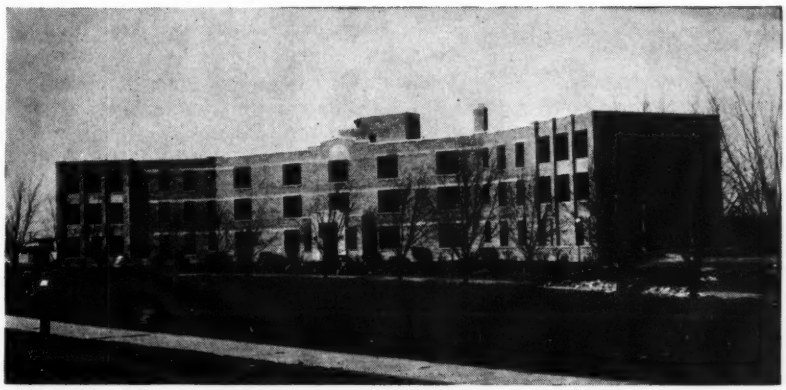
# Westminster Hospital Addition at London Completed



With the completion of an extensive building programme, Westminster Hospital at London, Ontario, is now equipped to care for the needs of the members of the Armed Forces as well as to continue its work with the veterans of the last war. Since its construction in 1918 the hospital has provided both general and mental treatment for conditions resulting from the last war. The new additions, built at a cost of $400,000, will enable the hospital to handle the casualties of the present war as well as acting as a general hospital and pensions centre for Military District No. 1.

Three new buildings—an active treatment pavilion, already in use, and two hospitalization units, have added about 400 beds, bringing the total accommodation to over 1300 beds.

The three-storey active treatment pavilion has accommodation for 103 patients and houses laboratory and physiotherapy, dental and x-ray departments and the operating room. The modern x-ray department is used for both examination of recruits and x-ray therapy. Special rooms are set aside as eye, ear, nose and throat clinics and an electrocardiograph room has been provided for the examination of heart cases. There is a special ward for casualties among overseas nursing sisters. The pavilion has its own diet kitchen.

Wards in the pavilion are wired for radio and a fine library has been furnished for the men. Acoustical treatment of the ceilings has reduced the noise in corridors.

The hospitalization units will, it is understood, be used largely for convalescent patients. A cafeteria will be located in the basement of one unit for the use of up-patients, and a canteen is being furnished in the basement of the other unit. Together these units supply 300 beds.

At present a staff of 302 serves the hospital. It includes 10 full-time and 6 part-time medical officers, a matron, 30 nursing sisters, 2 male nurses and 253 lay employees. Lt.-Col. Thomas Morrison, district administrator, supervises the operation of the hospital.

# A Tour of the London Voluntary Hospitals

## The King Edward's Hospital Fund Checks up on Damage by Air Raids

**(Passed by Censor)**

*This report, by an Investigator of the King's Fund and which is condensed herewith, deals only with voluntary hospitals and does not report on the several score of hospitals which come under the London County Council and which have suffered considerable damage. Since this report was written we understand that there have been at least three quite heavy raids over London with considerable damage to several hospitals.—Edit.*

EACH hospital has its own individual story to tell, and what a splendid saga these stories will make when the time comes to tell them in full! But in the general picture which may be given to-day there are outstanding features to which tribute might well be paid here and now. For example, the truly remarkable degree of improvisation, the determination to carry on. And this combination of will and ingenuity provided striking illustrations of the value and importance of flexibility in administration and service.

**There was the will; they found the way ...**

*St. Thomas's.* When the dispensary had been destroyed and all the wards put out of action at St. Thomas's they quickly got 72 beds going in the basement. All sorts of queer places were instantly prepared and brought into use—coal cellars, stores, etc.,—for outpatients, staff accommodation, dispensing. The temporary operating theatre and sterilizing department were improvisations, too, although they owed their existence underground and in odd corners to foresight rather than sudden emergency.

**I Shall Long Remember ...**

At *Guy's,* also, beds were rushed up in a variety of unusual retreats when the surgical wing was bombed and the central staircase put out of action. Equally fine was the way Guy's carried on with that quiet orderliness natural to hospital life in wards lucky enough to escape damage. I shall long remember the thrill I experienced when, just beyond the heap of rubble left by a raider, I found myself in a ward where the peace and restfulness made the war seem hundreds of miles away.

On that terrible night when the *West End Hospital* was hit by a high explosive, an oil bomb and a number of incendiary bombs, all in quick succession, the first thought of the staff was, How can we carry on? Messrs. Debenham offered the use of 77 Welbeck Street as temporary accommodation. The offer was accepted without hesitation, and such was the flexibility of management that the out-patient work was continued without the loss of a single day!

*St. John's Hospital,* Lewisham, has suffered £30,000 worth of damage, but is maintaining all its services today. A striking example of the will to carry on despite enemy attack is afforded there by the use of the Chapel as a massage department. That is being done with the consent of the Bishop of Woolwich, who has also blessed a part of the Sisters' dining room so that it can be used for divine service in substitution for the Chapel.

**Co-operative Service in Time of Need**

Next I would mention the admirable spontaneous way in which hospitals have given assistance to each other. On that night of triple attack on the West End Hospital several others promptly offered assistance, thus enabling the work of the in-patient department to be carried on without interruption. At two o'clock one morning the Great Ormonde Street Hospital for Sick Children was in grave danger through a bomb bursting in Guildford Street. Before the danger could materialize all the little patients had been transferred to the National Queen Square. When the Miller Hospital was badly damaged, Guy's sent supplies and the Dreadnought Hospital lent bathrooms for nurses. Voluntary hospitals have accepted patients from municipal hospitals, and vice versa. The only inspiration needed has been the opportunity for service to the sick.

**Relatively Few Casualties**

Then there is the remarkable fact that relatively few patients in voluntary hospitals have become raid casualties. Generally speaking this was due to organization and foresight, although good fortune has also played a part. In one case only a few hours separated the evacuation and the bombing. The practice (of voluntary hospitals) of keeping the upper storeys empty, particularly in the case of modern buildings, has played an important part in keeping the casualty list low. At Great Or-

*A children's hospital—after a German dive bomber had made it his target.*

# Over 100 Military Hospitals under Canadian Administration

## Brigadier Gorssline Describes Huge Undertaking

In 1939 there were but 10 small military hospitals with a total capacity of 372 beds. At the present time there are 72 military hospitals on the Home War Establishment and 2 in Newfoundland, with a total capacity of over 5,900 beds, stated Brigadier Gorssline, Director General of Medical Services, in addressing a crowded luncheon meeting at the Canadian Medical Association convention in Winnipeg.

To these 74 hospitals should be added 27 hospitals for prisoners of war and internees with a capacity of 500 beds, and 3 hospitals overseas —a neurological hospital, a casualty clearing station and a convalescent depot, these three having some 3,800 beds.

As of June 24, 1941, there were 1,004 Medical Officers on the R.C.A.M.C. strength. Of these 698 were in Canada and 306 overseas. As of May 31st, 1941, there were also 319 medical officers in the Air Force, 8 being overseas and 94 in the Navy, 24 being overseas.

The R.C.A.M.C. also had on June 24th, 1941, 670 nursing sisters, of whom 236 were overseas. The Air Force had 75 nursing sisters, all in Canada.

Hospital admissions have necessitated ample accommodation. In Canada, from September, 1939, to May, 1941, there were 120,722 admissions, the average length of stay being 12 days. These were from the Active Army only and did not cover the R.C.A.F., Navy, or Reserve Formations. During 1940, admissions in the United Kingdom from the Canadian Active Army amounted to 13,005, with an average duration of 18 days. Influenza and colds were responsible for about one-quarter of the admissions.

Up to the end of April of this year 328,325 recruits had had x-ray examinations of the chest. Rejections from this study were 1.6 per cent, 58% of the group having pulmonary tuberculosis.

The importance of re-examinations was stressed. Apparently the change from a sedentary to an active life is apt to show up physical changes or weaknesses not previously recognized.

Two courses for x-ray technicians and one course for laboratory assistants have been held. There has also been a four months' course for radiologists and two courses in tropical medicine.

### More Doctors Needed

"More medical officers are required", stated Brigadier Gorssline. "We need doctors — and we need them badly." Three hundred more are needed this year and at least as many next year. Doctors under 40 are needed for overseas service and older doctors, not necessarily fully physically fit, for service in Canada.

The D. G. M. S. referred to the action of some young doctors who were interested in joining only if they could be assured of a special type of work. Said the Brigadier, "Doctors should join the Army to serve their country, not to obtain a postgraduate course".

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monde Street, for example, the children escaped because they were kept on the first floor, below that in which the bomb exploded.

May I mention briefly the other hospitals I visited in addition to those named above. Their sacrifice and service calls for the highest praise although here one has room only for little more than a hint of all they have done and suffered.

*London Homoeopathic Hospital*— Twice bombed and once fired. Four of the staff decorated for bravery. Despite all the damage the hospital carried on.

*Dreadnought Hospital* — Half of the west wing demolished by a 1500 pound bomb and the other half rendered unsafe. Ingenious use is being made of the east wing.

*Prince of Wales Hospital*—Physiotherapy and massage departments destroyed together with a great deal of valuable electrical equipment.

*City of London Maternity Hospital*—A direct hit destroyed one ward block, not long after the patients had been moved to the safety of the passages.

*Royal Northern Hospital* — This group has been hit 14 times and between £80,000 and £90,000 worth of damage done. One bomb wrecked the whole in-patient department, injuring everyone in it and killing one person. The department will have to be rebuilt. The radiographer's foresight in wrapping pillows round the more fragile parts of a new x-ray plant and loosening screws saved it from damage.

*Catholic Nursing Institute.* Half now useless. The Reverend Mother and two sisters were killed searching for incendiaries on the first floor. The rest of the staff were safe in the basement.

*Westminster Hospital.* Hit four times, total damage £15,000.

*Princess Beatrice Hospital.* Thirty air raid casualties were being treated in the operating theatres and wards when the hospital was hit. The work went on.

*National Temperance Hospital.* All beds in the main block put out of action by a bomb.

*London Jewish Hospital.* Normal work interrupted since last October, when a bomb destroyed the administrative offices and all records.

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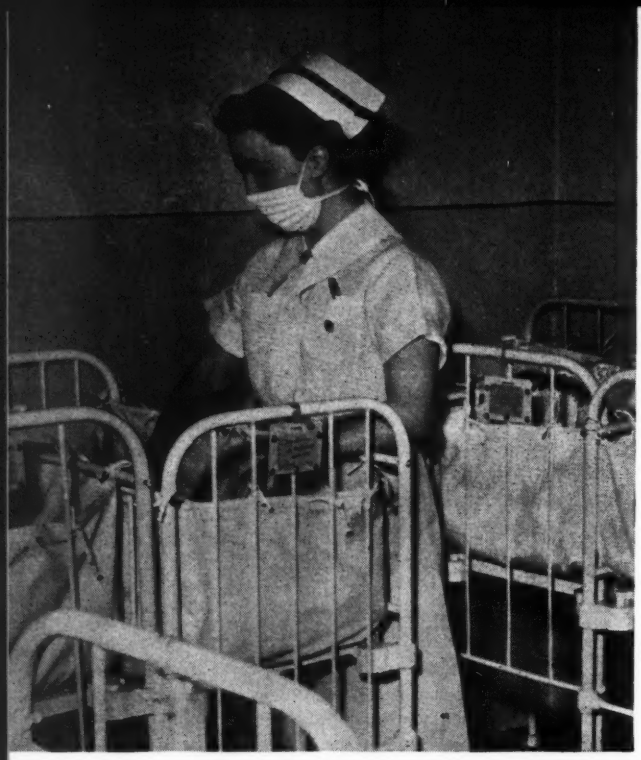
### Dr A. E. Archer of Alberta President-Elect, C. M. A.

Dr. A. E. Archer of Lamont, Alberta, has been made President-Elect of the Canadian Medical Association. Dr. Archer has long taken an active interest in hospital work in Alberta, being a former president of the Alberta Hospital Association. He has also been president of the Alberta Medical Association (C. M. A. — Alberta Division) and president of the Alberta College of Physicians and Surgeons. Dr. Archer is one of the best known surgeons in western Canada. He had also taken an active part in the study committee work of the Canadian Hospital Council.



# TO MASK
# OR NOT TO MASK

## --that is the question

## Vancouver Paediatrician Doubts Wisdom of Common Practice

AN interesting point has been raised by Dr. Howard Spohn, prominent paediatrician of Vancouver and secretary of the British Columbia Medical Association. Dr. Spohn's letter is here quoted with comments from several well known authorities.

**Dr. Spohn's Letter**

"There is a problem which I would very much like to have discussed and that is the *wearing of masks by nurses on duty in the nursery and paediatric wards.* I have made a rule in the paediatric department at St. Paul's Hospital here to the effect that no nurse on duty should wear a mask during the day for the simple reason that when a mask is worn for long periods of time it collects a concentration of bacteria which are scattered about when the mask is turned down. If a nurse has an infection, no matter how slight, she should not be on duty, in either the maternity or paediatric ward especially. We feel that masks worn for hours in such a way are far more harmful than if no masks were worn at all.

The wearing of masks during an operation is an entirely different affair. However, I have seen, even in university hospitals in Toronto and other places, house surgeons going through half the day with the same masks. Most of the time these flap about in front of the chest and then they are turned up to collect more bacteria and these are scattered about. I doubt whether any human being can wear a mask for three or four hours without touching his face because of the uncomfortable sensation of the mask. Most people do this unconsciously and nurses' hands are in this way easily contaminated. This may seem a very trivial matter, but very little common sense has been shown in the ridiculous way in which masks are used. Skin infections still continue to appear in hospital nurseries and impetiginous infection during the first few weeks of life is undoubtedly a hospital disease. It would be a very excellent thing for hospital associations to set out a uniform technique which should be adhered to rigidly in all standard hospitals.

*Yours sincerely,*
(Signed) HOWARD SPOHN."

Dr. Spohn's letter was referred to Dr. Alan Brown, Professor of Paediatrics at the University of Toronto and Physician-in-Chief at the Hospital for Sick Children. The following comment was drafted in co-operation with his assistant, Dr. Elizabeth Chant Robertson, who has conducted extensive research on the provision of cross infection.

**Dr. Alan Brown's Comments**

"Dr. Charles F. McKhann, formerly of Harvard University Medical School and now Professor of Paediatrics in the University of Michigan, has done some very striking experiments with different types of masks, which unfortunately has not as yet been published. However, he told us of his results which were obtained by two methods: First, by spraying organisms through the masks and catching them on the other side on agar plates; and second, by having people sneeze through them and taking very fast photographs during the process when the face was brightly illuminated from the side.

"He found that masks made out of the ordinary gauze or butter cloth, even when 6 or 8 thicknesses were used, allowed bacteria to go through without hindrance. When a piece of flannelette was put between two layers of gauze, the bacteria were practically all caught in the interstices of the flannelette. Some weaves of flannelette were considerably more effective than others.

"We have been using this type of mask in many of the wards of the hospital for the last few months. They are somewhat warmer to wear than the regular type of mask but their efficiency is incomparably greater. I

doubt very much whether the bacteria caught in the flannelette would be dislodged when the mask is taken down and flaps about on the chest, but we have no data as yet on this question. We are using a hand disinfectant in the form of a modified dettol cream so the fact that the wearer handles the mask is not so serious as if the hands were heavily contaminated."

*Yours very truly,*
(Signed) ALAN BROWN."

Dr. Gordon Chown, Physician-in-Chief to the Children's Hospital of Winnipeg, and Assistant Professor of Paediatrics at the University of Manitoba, makes the following comment.

**Dr. Chown's Comments**

"With reference your letter of the 5th instant, I may say that I am heartily in accord with the facts contained in Dr. Spohn's letter.

"Masks are not worn in the Children's Hospital in Winnipeg as a routine. Masks and gowns are only used in the premature ward by the nurses.

"I submitted Dr. Spohn's letter to Dr. Bruce Chown, Superintendent of the Children's Hospital. He is entirely in agreement with Dr. Spohn.

"In the Winnipeg General Hospital obstetrical department the masks are filed in small boxes, with the intern's name above. I am unaware of the interval of time which elapses before fresh masks are provided.

*Sincerely yours,*
(Signed) GORDON CHOWN."

Dr. Alton Goldbloom, Assistant Professor of Paediatrics at McGill University and head of the department of paediatrics at the Jewish General Hospital, Montreal, makes the following comment:

**Dr. Goldbloom's Remarks**

"Dr. Spohn deserves a great deal of credit for his courage in bringing into the open a subject which for a long time has required discussion.

"I agree unqualifiedly with his statement that masks, as they are at present in use by ward nurses are not only useless but may well be a source of infection; that in a healthy individual there is comparatively little danger of transmitting infection to a healthy infant; and that in an infected individual no mask is of any value.

*Yours sincerely,*
(Signed) ALTON GOLDBLOOM."

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# Intern Schedules for 1942 Still Unsettled

The intern situation for 1942 is still far from settled. In fact the situation is more confused now than it was a month ago. In our June issue we reported that the deans of medical schools at a meeting in Ottawa had agreed to hasten the output of doctors by starting the fall sessions earlier this summer and by ultimately planning to graduate three classes every twenty-four months. Hospitals were to be requested to change their schedules for interns to eight months.

Since then Ottawa, after receiving budgets of anticipated costs from a number of the schools, has notified the schools that this arrangement could not be financed. As a result some of the schools have decided to make no change in their existing schedules while others will speed up the course anyway, irrespective of financial support. Manitoba will make no change this year except that the students may be called back 10 days earlier. Alberta and Western Ontario will start early in July. Toronto will start August 25th. Queens retains its former schedule, McGill will carry on very much as hitherto and Montreal will do likewise. Word has not been received respecting Laval or Dalhousie.

This situation is very unsatisfactory from the viewpoint of the hospitals. Some students will be available for internship by the end of March, some in April and some on May 1st. Others will not graduate until the usual time. Where the hospitals in a centre such as Montreal, Halifax or Winnipeg obtain their interns largely from the one school, the situation can be handled without too much difficulty; the situation is more serious, however, in those hospitals where it has been customary to draw interns from a number of medical schools. Either schedules will need to be developed which permit elasticity in the inclusion or dropping of interns, or else hospitals away from teaching centres will find it desirable to endeavour to obtain interns from one school only, or schools with similar graduating months, and draw up their intern schedules to suit those dates. Whether or not the Canadian Intern Board can continue to function under these circumstances has not been determined.

## Canadian Dietetic Association Holds Successful Annual Meeting

The dietitian's contribution to national nutrition was the featured topic of the sixth annual meeting of the Canadian Dietetic Association held June 21st at the Household Science Building, University of Toronto. Dr. Harold Crouch, of Toronto, guest speaker at the dinner held that night at the Thornhill Golf Club, stressed this subject in his address, "Total War — This Means You".

Officers elected for 1941-42 are: Honorary president, Frances McNally, Acadia University; honorary vice-president, Dr. Jessie Brodie, University of Toronto; president, Grace Sharpe, Ottawa Civic Hospital; president-elect, Ethel Pipes, Vancouver General Hospital, secretary-treasurer, Laura Pepper, Director, Consumers Service, Dominion Department of Agriculture, Ottawa; reporting secretary, Evelyn O'Neil, University Club, Ottawa; vice-president, Mrs. Gordon Petrie; membership secretary, Nancy Shepard, Royal Victoria Hospital, Montreal; director for western provinces, Collena Nickel, Colonel Belcher Hospital, Calgary.

# Obiter Dicta

## *C. I. O. Under Fire*

HOSPITALS in this country have been free of any serious labour disputes for several years, but our sister hospitals to the south are continuing to have occasional strikes and frequent threatenings of strikes. History would now seem to be repeating itself for in the last war labour seized the opportunity of shortage of manpower and urgency of orders to make stiff demands — *or else*. Frequently this was justified, for profits in that war were often quite unjustifiable. This time excessive profits would seem to be well controlled, primarily in setting the contract price and, later, by the high excess profits tax.

The recent warning of the President of the Canadian Manufacturers' Association has provoked serious thought. "Demands for large increases of wages and control of plant operations have multiplied." This "sinister change" would seem to be "promoted by small minority groups who are seeking to acquire influence over thousands of new workers in industry". To quote the telegram sent by the Association to the Prime Minister, "groups of dangerous men are trying to seize control of the key war industries of this country, in order to control the workers and to make a levy on wages that are paid to the workers and to obstruct and restrict the output of munitions which are so sorely needed in the war".

It is of interest to note that the A. F. of L. on May 28th directed all its affiliates to refrain from striking against defence industries until all possibilities of mediation have been exhausted. That is a commendable move. Apparently the A. F. of L. is trying to co-operate in the war effort. *The Labor Leader* (Toronto) states: "In a recent survey it was shown that 95 per cent of all strikes called on the North American Continent during the past twelve months were called by unions operating under the C. I. O. It has long since been proved that the C. I. O. is dominated by Communists ... (who) consistently refuse to support President Roosevelt in his efforts to send all-out aid to Britain."

Whether or not the C. I. O. policy is directed by the Communists and the Nazis, as so often claimed, or is merely a shortsighted policy to obtain immediate gains at all costs, regardless of the future, is not for us to state. But it is known that, in hospital circles, the A. F. of L. has been much more co-operative. A few years ago when hospital staffs all over the continent were being actively unionized by both organizations and strikes of serious danger to hospital patients were being staged, the American Hospital Association discussed the matter frankly with the leaders of both organizations. The leaders of the A. F. of L. immediately appreciated that the hospital situation was different, agreed to refrain from strikes and even agreed to suspend organizational activities until a survey of labour conditions in hospitals could be made by the American Hospital Association. Their full co-operation was proffered. Since then, to the best of our knowledge, no A. F. of L. strikes have occurred in hospitals. On the other hand it is understood that the delegation was told by the C. I. O. that strikes in hospitals could be anticipated if such action suited their (C. I. O.) purpose. Public welfare would seem to be of secondary consideration.

Civilian hospitals are hardly to be classed as essential war industries and, therefore, are not specifically indicated in the appeal to the Government to outlaw and stop subversive strikes endangering the national war effort. At the same time our hospitals are an essential civilian activity of the first order and their continued operation at all times must be closely guarded. Whether or not hospital personnel should organize is not the question — most hospitals with unionized staffs seem to be getting along very satisfactorily — but it is most vital, from the viewpoint of the public weal, that such organization as does occur be on the distinct understanding that it is for purposes of negotiation, not of wielding threatening clubs which fall, in the final analysis, not upon the hospital administration but upon the helpless sick.

## *Training for Administration*

THE announcement of a one-year course devoted entirely to hospital administration by the School of Nursing of the University of Toronto is in keeping with the present trend towards insistence upon adequate training for the post of administrator. This would seem like a timely development, too, because, on the conclusion of the war, there will be many nursing sisters who will desire to go into the administrative field and who will realize that a year of special training would be time well spent.

Hospital administration is altogether too serious a responsibility to be undertaken without adequate qualification. Some boards still select an administrator on what appear to be exceedingly flimsy reasons but gradually boards are insisting upon better qualifications when selecting an administrator. With higher standards, too, we may expect less turnover in administrative personnel, a situation which has been discouraging to all concerned. With a general training in business principles—accounting, collections, purchasing, etc.—the nurse administrators of the smaller hospitals would be in a better position to direct, or undertake in the case of purchasing, the activities of these departments. While adequate knowledge may be obtained by actual experience in these departments, the vast majority of nurses who become administrators reach that post from the wards rather than from the business office.

Recently we were asked why, when a hospital becomes of any size, the Board so often replaces the nurse superintendent by a layman. Is it worthwhile for a nurse to take a course in administration? One's immediate answer, albeit entirely a personal one, is that Boards as a whole have no antipathy to nurse administrators; some of the best operated hospitals in Canada—and large ones, too—are operated by nurses and by Sister-nurses. But if the nurse administrator's only qualification is her nursing background and the Board feels that the hospital needs someone who can give it *business* leadership and directions, who can cut deficits, or go out and stir up community support for a new building and who can talk the language of the engineer, the laundry foreman, the market sheet and the supply house, it is only natural that such a Board is going to consider appointing a lay administrator who is trained to do many of the duties often assumed by Board members or committees when they have a nurse administrator. The same logic applies to the medical administrator who does not become a competent business man as well as physician.

It is because there is a real field, and one without limit, for the nurse administrator that this course has been arranged. When Boards find that the nurse administrators are trained to meet the varied and multitudinous problems of administration as well or better than other types of applicants, there will be no question about future openings for those qualified.

## *The World We Want*

AS THE frontier of continents has disappeared, its place has been taken by the frontier of science, and no one can foresee the effect which the indefinite extension of its borders will have upon mankind. But, no matter how much his life will be changed by invention and discovery, man will continue to want from this world freedom, social justice, economic and political security. He wants a world in which human intelligence will organize and distribute the ample resources of nature so that all can live abundantly; a world in which intelligence will be devoted to human progress rather than to destruction; a world in which a man's labour may be directed toward his own advancement. This is largely a problem for local and national governments, but they cannot solve it alone. The labouring man knows that his living standards are affected by the living standards of other countries; the agricultural man must face the fact that he can dispose of his crops only in a world-wide market; the industrial man may find his factory idle because of inability to secure needed materials, or markets, in other lands. These, and many other matters upon which the happiness of the individual rests, are problems which can only be solved internationally.

If we have the courage to lift our eyes above the agony of the moment, we may see a world in which the forces of applied science and the diffusion of knowledge offer to all men and nations a plane of living, a freedom and richness of spiritual, cultural, and economic attainment that can scarcely be imagined at the present moment.

Peace under modern conditions cannot be a static condition of life achieved by the renunciation of war, nor a mere pious desire to live at peace. Peace must be a dynamic and continuous process for the achievement of freedom, justice, progress and security on a world-wide scale. Many problems can never be finally solved. They recur in different forms as eternally as life itself. The processes of peace, however, should make possible ways of meeting these emerging problems on a plane higher than mass physical combat.

Peace requires the substitution for war, which becomes ever more destructive, of international processes which while protecting national ways of life against external violence, will facilitate adaptation to new conditions and will promote creative changes in the general interest. Peace involves whatever international organization is necessary under conditions of the times to protect the interests and promote the progress of mankind. The world has so shrunk that the loose political organization of the past which rested on balance of power, on neutrality and isolation, is no longer adequate.

*From the Preliminary Report of the Commission to Study the Organization of Peace, in "International Conciliation", April, 1941.*

## *Public Hospitals not under Unemployment Insurance*

EMPLOYEES of any hospital or charitable institution "where in the opinion of the Commission such hospital or charitable institution is not carried on for the purpose of gain" do not need to contribute under the national unemployment insurance plan which went into operation this month. Those who do professional nursing for the sick or who are "nurse probationers" (presumably undergraduate or student nurses) also are exempt.

Twenty-one groups of employees are not covered; otherwise the measure applies to all employees receiving $2,000 per annum or less. Among the groups not covered are farmers, fishermen, woodsmen, air and water transport workers, domestics, teachers, members of the armed forces, policemen, federal or provincial civil servants (except by special arrangement), casual employment, and agents under certain conditions.

# Should the Hospitals Pay Anaesthetists a Salary?

## 21 Larger Hospitals State Their Arrangements

AN inquiry was made by the Canadian Hospital Council of twenty-three larger hospitals in Canada, teaching and non-teaching, respecting the remuneration paid to their anaesthetists. Twenty-one of the twenty-three hospitals replied and these replies are summarized below. In all instances these refer to medical anaesthetists. The administration of anaesthetics by nurse anaesthetists is contrary to provincial enactments in Canada, nurse anaesthetists being employed very rarely and only where the doctor takes full responsibility.

### No Salary

Nine (9) hospitals pay no salary to staff anaesthetists either for care of ward patients or for teaching interns.

### Part-Time Employment (7 Hospitals)

*Hospital 1* (300-400 bed group) (in one of the prairie provinces) pays $300 per year to the anaesthetist to supervise the maintenance of equipment and to instruct interns. This hospital follows the custom in many prairie hospitals of not recognizing ward patients as indigent or staff cases.

*Hospital 2* (300-400 bed group—in the same province) pays $900 per year and the anaesthetist also has the use of an office in the hospital with telephone. He gives training to the interns and looks after the department of anaesthesia in regard to records and equipment. The interns give anaesthetics to public ward patients for which no charge is made to the patient. If the attending physician requests the staff anaesthetist he can do so and the patient is charged directly for his services.

*Hospital 3* (300-500 bed group) has two part-time attending anaesthetists on call at all times. The chief anaesthetist is paid $3,000 a year and his assistant $1,200. The chief anaesthetist gives instruction to interns.

*Hospital 4* (200-300 bed group—teaching) has three part-time attending anaesthetists who each receive an honorarium of $500 per year. They usually have, also, two resident physicians who, among other professional duties, assist in the administration of anaesthetics. They receive approximately $1,500 each per year with maintenance.

*Hospital 5* (500-700 bed group—teaching) pays staff anaesthetists for morning hours. The rates are: chief anaesthetist $6,000; three assistant anaesthetists $3,000 each. In addition they have a resident anaesthetist who receives $1,200 per year and full maintenance. Staff anaesthetists are on call in rotation for work after regular hours for either private or public patients. Most public cases are served by the resident or trained interns except where, in the opinion of the staff surgeon, the anaesthetic risk is a bad one. Interns are trained by the chief anaesthetist.

*Hospital 6* (300-500 bed group) has four staff anaesthetists on regular payroll but the amount of salary is not stated. The slate is from 8 a.m. to 1 p.m. If an emergency arises after one o'clock the anaesthetists are called in rotation and receive $5.00 for each anaesthetic given. This is charged to the patient by the hospital. No anaesthetic is given by student interns but the chief of the anaesthetic staff gives lessons and demonstrations to the interns.

*Hospital 7* (300-500 bed group). The doctors on the anaesthetic service at this hospital are given $500 per month to be distributed between them after arrangement to this effect.

### Full-time Employment

Five (5) of the twenty-one hospitals replying have full-time anaesthetists on their payrolls.

*Hospital 8* (700 and over bed group) has six full-time anaesthetists on the payroll. The director of the anaesthetic department receives $5,940 per year, four anaesthetists receive $4,260 and one receives $3,060. The personnel of the department take care of all anaesthetic work in the hospital and the hospital bills the patients for the services rendered. The department also takes care of the training of interns.

*Hospital 9* (700 and over bed group—teaching). All anaesthetists are on salary ranging from about $6,000 a year down to $3,000. They also have resident anaesthetists who receive $50 or $100 a month.

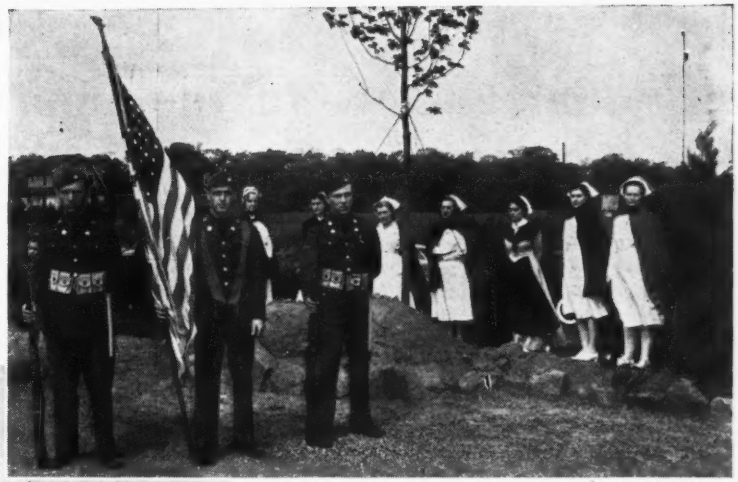
*Hospital 10* (500-700 bed group—teaching) has 6 full-time anaesthetists with salaries ranging from $8,000 to $1,200.

*Hospital 11* (300-400 bed group—teaching) has two full-time anaesthetists—the chief receives $6,000 a year and the assistant $1,800 a year with a raise to $2,400 for the second year if satisfactory. They must give twenty-four hour service. However, during hours not occupied by this hospital they may carry on the practice for remuneration in any other hospital, institution or office (in this sense, therefore, not entirely full-time). The hospital collects all anaesthetic fees except that the chief anaesthetist collects and receives all fees arising from patients hospitalized under the authority of the Workmen's Compensation Board.

*Hospital 12* (200-300 bed group—teaching). Anaesthetics are administered by four full-time anaesthetists with salaries ranging from $5,000 to $3,300 a year.

**East is East and West is West and never the twain shall meet . . . But watch them get together at the Canadian Hospital Council meeting in Montreal, September 10th and 11th. For hospital problems don't stop at geographical fences — and neither do hospital people. They'll come from the Maritimes and the Rockies, from small rural hospitals and from the biggest city hospitals—and they want you to be with them!**

## Tree Planting During Celebration of National Hospital Day



The planting of a 22-foot Canadian maple in memory of Sir Frederick Banting, during National Hospital Day celebrations at the Richmond Memorial Hospital, Dreyfus Foundation, Staten Island, N.Y., honoured a man whose contribution to the world and whose spirit were international in the finest sense of the word. As Prime Minister Mackenzie King stated in a telegram: "Your tribute is a recognition by the Canadian and American peoples that the hopes of mankind are founded in the selfless service to humanity which ennobled Sir Frederick Banting's life and inspired his labours."

It was also a gracious gesture, typical at this time of the sympathetic relations between the two countries. In editorial comment the Staten Island *Transcript* paid tribute to the war effort of the Canadian people when it stated "The planting of the Banting Memorial Tree is more than a memorial to one man. It is our community's expression of gratitude to the many Canadians who have directly aided us through their accomplishments in the medical profession and, in a still larger sense, it is our community's expression of thanks to the whole Dominion of Canada which to-day, in war, is giving its whole great heart to the fulfilment of the highest hopes of humanity."

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## One Year Course in Hospital Administration Offered by U. of T. School of Nursing

This autumn the School of Nursing of the University of Toronto is offering a year's course in hospital administration for a limited number of experienced nurses who wish to prepare for the position of hospital administrator. Although nurses have repeatedly asked for this training and hospitals have sought nurses with it, there has been, so far, no adequate course in Canada. The present course, therefore, meets a definite need.

Instruction will be given in economics, business and accounting methods, psychology, legal aspects of hospital administration, hospital organization and administration, and public health. Toward the end of the year, each student will have two months of administrative practice in hospital.

Anyone wishing further information may obtain the school calendar from the Secretary, The School of Nursing, University of Toronto.

### U. of T. Extension Course in Hospital Administration Scheduled for November

In November, 1941, as for several years past, an extension course of two weeks in Hospital Administration will be given at the School of Nursing, University of Toronto, if sufficient applications are received. The course will include lectures by authorities in hospital administration, as well as visits to Toronto hospitals, demonstrations and discussions. Enquiries should be addressed to the Secretary, School of Nursing, University of Toronto.

# Essential Factors in the Internship

## A Medical Superintendent Follows Up the Article "Making Jack a Dull Boy".

***By F. A. LOGAN, M.B.***
***Assistant Superintendent Medical, Toronto General Hospital***

*In our May issue (p. 20) we published an article on interns entitled "Making Jack a Dull Boy" by Dr. R. A. Seymour, Assistant Superintendent, Vancouver General Hospital. In the following letter, Dr. F. A. Logan, Assistant Superintendent Medical of the Toronto General Hospital, differs with some of the findings, particularly respecting "Time Off".*

*—Editor.*

THE Diploma of the Medical Council of Canada, plus a provincial licence, entitle a recent graduate to practise his profession immediately, but very few young doctors consider they are sufficiently qualified to do so without post-graduate training or an internship. Our hospitals provide facilities for such practical training. Intern appointments are now made through the Canadian Intern Board, by which means interns select the hospital they desire for their training and hospitals accept the doctors who they believe will be most suitable. Both parties to any such plan have definite obligations and responsibilities which are to the advantage of the other party.

The intern, as a rule, wishes an opportunity to make the best use of his time in post-graduate study, and in return the hospital expects that he will render a conscientious and satisfactory service for the welfare of the patients he is called upon to attend under the supervision of the visiting staff.

### The Hospital's Responsibility

The hospital should be prepared to provide satisfactory living quarters, good wholesome meals, uniforms and laundry service. The primary requisite for post-graduate training must be facilities for adequate clinical investigation and study, under a "teaching" medical staff. This should be possible whether or not a hospital is in a university centre. An interns' library where one may study should be encouraged. This is particularly desirable if a Journal Club is in operation; under any circumstances it stimulates the reading of current articles in the best journals.

Recreation facilities should be provided for both indoor and outdoor sports. This has not always been satisfactorily arranged and should be seriously considered. Relaxation when off duty is necessary for every intern. Billiards and table tennis are good games for indoors and tennis serves for exercise during the summer months. Golf may be feasible in certain cities while in others transportation problems and expense make this sport difficult. Squash or badminton would seem desirable for the intern during the winter months. If facilities are available on the hospital grounds these sports will be indulged in much more frequently and with more benefit.

### The Intern's Responsibility

Assuming that the above requirements are met by the hospital what may one expect from a doctor accepting an intern appointment?

The first major expectation is that the young doctor should now realize that, by reason of his graduation from university and his possession of a diploma to practise medicine, he must accept *responsibility*. The hospital, medical staff and patients assume that this responsibility will be borne in such a manner that their complete confidence may be placed in him.

### Time Off

One does not concur with the suggestion in a recent article "Making Jack a Dull Boy", that an intern is a hospital employee, but rather a member of its indoor medical staff. If this be so, the doctor may resent being treated as a school boy by being given definite hours of duty, which he knows full well he will never be able to observe once he has started to practise. It may be unfortunate for the medical profession, but illness strikes the apparently healthy individual irrespective of time and that person has a right to expect adequate medical service when admitted to hospital. The visiting members of the medical staff are always willing to be consulted, apart from their regular hours. If the intern takes too much time off duty, he, unfortunately, will not be able to observe many clinical problems with which he should be acquainted.

Every hospital must deal with its individual problem as to the time "off duty" a particular intern requires. The health of the resident staff should always be of paramount importance. Every doctor should have an x-ray of his chest when he begins his post-graduate training and thereafter at least yearly. Instructions should be given regarding the methods he should observe when examining any patient, to prevent infection. Volunteering as a blood donor too frequently should be discouraged. The necessity of discontinuing work immediately if not feeling well should be insisted upon and early hospitalization with a minor illness often lessens the time off duty. The time "'off duty" for an intern cannot be determined definitely.

### Laboratory Work

Every hospital administrator knows that an accurate medical record is essential to good treatment. The young doctor who has this fact

(*Continued on page* 44)

# More Cash on Admission Best Solution

*By STANLEY W. NICHOLS,*
*Union Hospital,*
*Indian Head, Saskatchewan*

HOW can the hospital adjust itself to increasing costs? Should rates be increased or services modified? This question cannot be answered directly by either suggested answer.

*Increased rates* would be a distinct hardship on Saskatchewan hospital patients as we have not seen any noticeable increase in income yet. If the war follows the course of wars of the past, this can be looked for later and an increase in rates would then be justified, but at present an increased charge for hospital services would be very unpopular and would tend to antagonize the debtor and thereby encourage him to leave the account unsettled as far as possible.

*Should services be revised?* Most hospital managements will agree that this method of effecting economy has been gone into very thoroughly every few months for a number of years and very little more can be done without reducing efficiency or curtailing services.

We must not consider anything that will interfere with efficiency.

Reduction in staff does not seem possible as many hospitals, particularly the smaller ones, have found it impossible to get down to an eight-hour day for the nurse. One sees little hope of any saving there.

Reduced salaries are also impossible. Canadian hospitals pay on an average much lower salaries than do American hospitals or does industry as a whole. The result has been a loss to us of many of our best nurses and supervisors. As nurses enlist for military service, the tendency will be for salaries to gradually increase.

We must therefore look elsewhere for an answer to our question.

The loss from *uncollectable accounts* has been the most serious problem in hospital management for years. While we have reduced our losses in recent years by insisting on someone being responsible for every patient, there is still an enormous sum marked off each year by our hospitals. Temporarily, the situation may look after itself. As unemployment and poverty are reduced by enlistments and other war activities, more people will be able to pay their way and uncollectable accounts will be less numerous. This, however, is but a passing and partial solution.

### The Logical Solution

At Indian Head about a year and a half ago we were running short of money. We found we were only collecting about 30% of our earnings. As we were on a strictly cash basis, something had to be done—and done quickly. We followed the lead set by Regina General and adopted a policy of *cash on admission,* insisting on the cash except in the most urgent cases. We had a little difficulty for a few weeks—not very much—and since then the plan has worked very smoothly and produced very gratifying results. We bought some war bonds the other day.

Many hospitals now follow this plan.

The best way to adjust ourselves to increased costs is to insist on more cash. Get people into the habit of bringing money with them when they come to hospital. They go out much more contented and have no grudge against the hospital if the bill is settled. Moreover, the hospital can carry on much more successfully with cash customers than with uncollectable accounts.

Given at the 1940 Saskatchewan Hospital Association Convention.

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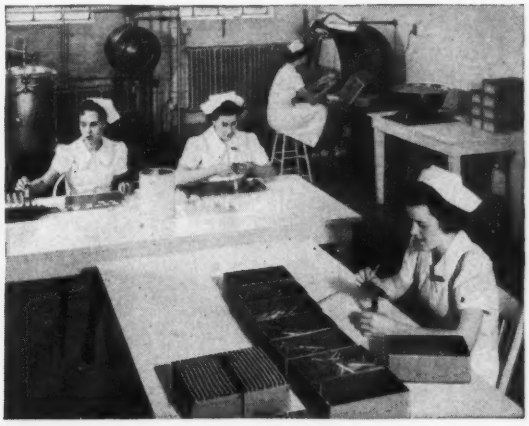
### Dr. W. Douglas Piercey Given New Post at Ottawa Civic

Dr. W. Douglas Piercey, Assistant Superintendent at the Ottawa Civic Hospital, has been appointed to the newly-created post of secretary of the hospital. Dr. Piercey was appointed assistant superintendent in January, 1940, and has been acting superintendent during Dr. Dobbie's absence on sick leave. His new position will give him added responsibilities in connection with the business administration of the hospital.

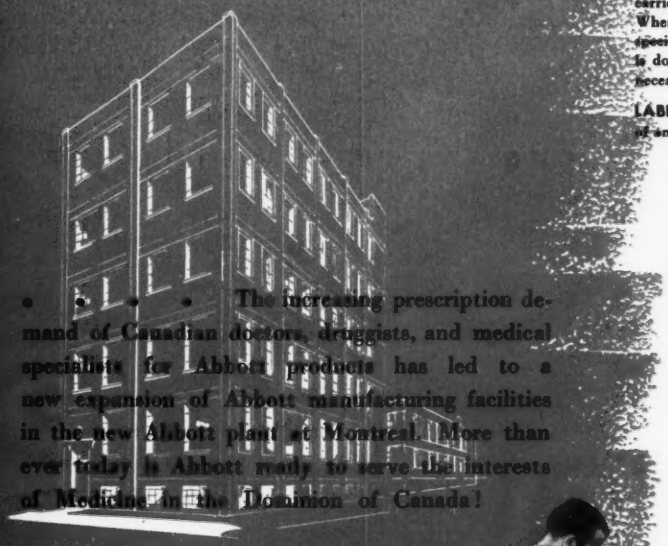
*Nursing Sisters of the Esquimalt Military Hospital, B.C., formed a guard of honour to receive His Excellency the Governor-General and Princess Alice when they visited the hospital.*

# MANUFACTURING FACILITIES IN CANADA



**LIQUID DEPARTMENT.** (Above left). Manufacture of liquids is carried on the fourth floor of the building where the tanks are housed. When the preparations are complete, they are passed, by means of special connections, to the floor below where the filling and packaging is done. Inset shows worker in liquid department wearing gas mask necessary in certain manufacturing processes.

**LABELLING SECTION.** Above is a general view of the labelling section of ampoule department.



• • • • The increasing prescription demand of Canadian doctors, druggists, and medical specialists for Abbott products has led to a new expansion of Abbott manufacturing facilities in the new Abbott plant at Montreal. More than ever today is Abbott ready to serve the interests of Medicine in the Dominion of Canada!

**AMPOULE DEPARTMENT.** The above illustration shows ampoules being thoroughly washed by a special process.

**TABLETS DEPARTMENT.** To the left is shown a section of the tablet department where many Abbott specialties are molded into the finished form. These machines can be adapted to other shapes besides the conventional tablet form, as shown in the illustration below.

**FINISHING DEPARTMENT.** The finishing department where Abbott products are finally dressed up before making their appearance on the drug store shelf.

**ABBOTT** • *Servant to Medicine* •

# With the Hospitals in Britain

*By "LONDONER"*

*Dear Mr. Editor,*

Sir Arthur Stanley, the Treasurer of St. Thomas's Hospital, London, has announced that a country branch is being established at Godalming in Surrey. The arrangement will provide evidence of the working of a theory which has been advanced many times. Sir Arthur observes, "that only the outpatients' departments and a sufficient number of beds for the admission of acute cases should be kept in London by the large hospitals and that the remaining beds should be located some miles out in the country where the patients would enjoy the blessings of pure air and freedom from noise". A similar step has been taken by Guy's Hospital in the establishment of a branch in the county of Kent.

It happens that a little trip which I made recently contributed information on the same point, while my notes may also give a glimpse of the Emergency Hospital Service created to meet conditions of war. I started from the London Fever Hospital which was described by Charles Dickens as "not only the single hospital of its kind in London but probably the best hospital of its kind in Europe" and still lays claim to that description. Upon the outbreak of war the Hospital had to abandon its normal work as the only voluntary hospital in London providing for infectious diseases in order to become a casualty hospital with one hundred beds, roughly half its ordinary number. Thus it represents the type of hospital advocated for the central areas where casualties could be received and as soon as possible transferred to the base hospital. This, however, as one surgeon observed, has the serious disadvantage that the doctor is unable to have the care of the patient throughout, though in peace time arrangements might be made to overcome this objection.

### Bombed-out Mothers

From Islington I proceeded out of London to Brocket Hall in the County of Hertford. It is a fine eighteenth century mansion standing in extensive grounds which has been the residence of two Prime Ministers, Pitt and Melbourne. Now it is the home of an eminent gynaecologist and obstetrician who acts as consultant for the whole of the County of Hertford. It has also become the refuge of expectant mothers who would normally have been received by the City of London Maternity Hospital, which has been so severely damaged by enemy action that it can no longer accept patients. Many of these women had not slept in a bed for weeks yet they had become reconciled to the conditions and even yearn to return to them in spite of the charm of their present surroundings. The matron emphasized the patients' point of view in these proposals to remove the hospitals from the centre. The location of this home is comparatively convenient for husbands and friends but even then it involves an hour's journey by bus and a fare of 3/- which is a serious matter for poor people. Conditions which make these arrangements acceptable in war time do not operate normally. People with the viewpoint of motorists, fail to appreciate the difficulties of patients and their visitors.

### A Satellite Town

The end of my journey took me to Luton, a town of nearly 70,000 inhabitants considerably augmented by people evacuated from the metropolitan area. Situated in Bedfordshire it is one of the satellite towns about thirty miles around the perimeter of London. Some of them have a strong corporate life which, as in this case, has found expression for its benevolence in the erection of an up-to-date voluntary hospital with about two hundred beds. The local authority, however, still has to make considerable provision. The job has been well done with obvious pride and a contributory scheme for the work people of the area supplies a substantial portion of the income. The emergency hospital service of the London area has been organized on the basis that towns at this distance are on the circumference and sectors have been formed like the sections of an orange. Movement of the patients is outwards, though if one of these hospitals were damaged seriously, there would be a lateral movement to adjoining sectors. There are people who see in this emergency organization the future plan for the regionalization of the hospital service on the basis of a thirty mile radius from central London. Even if the majority of the beds are only half that distance, like Brockett Hall, from the centre the necessary travelling is likely to deprive some patients of their visitors, though possibly the point seems to be somewhat exaggerated to readers accustomed to much greater distances.

### The Birmingham Hospital Centre

As a postscript to these comments on decentralization may I add a note of a recent experience on a visit to a patient in the Queen Elizabeth Hospital, Birmingham, which is the outstanding example in this country of a large hospital built in the outlying part of the City. On the way I called on the Secretary of another hospital who told me that it would take me over an hour to do the remainder of the journey by public transport, but which was accomplished in his car in six minutes. When I left the Queen Elizabeth Hospital there was no bus nor conveyance available at the end of the visiting time so I had to take a taxi —not a form of transport within the means of the friends of ordinary hospital patients.

# Here and There

*By THE EDITOR*

### Purists Flinch at "Hospitalization"

MR. H. P. BOULTER, Editor of *The Hospital Magazine* (Australia) writes in the May issue in defence of the use of the word "hospitalization" which has been attacked bv no less a personage than A. P. Herbert, the English M.P., and delightful humorist of London *Punch* fame, who included "hospitalization" among those words which are marked taboo in his entertaining book, "What A Word". Another member of the House of Commons has protested against the use of the same word, arguing that "it can scarcely be explained except by a passion for pointless illiteracy".

In his defence Mr. Boulter states: "Both politicians are right up to the point that 'hospitalization' is not a pretty word. However, people who are engaged permanently in hospital work would have great difficulty in finding another that would serve so useful a purpose in these days of efficiency hustle. By the use of this word many others are obviated in the course of correspondence and in the compilation of returns. Why gloss over the ugliness of disease with a pretty word? We do not term a murderer an eliminator, nor a pickpocket a prestidigitator. There are many other words in the English language that are ponderous and not nearly so convenient (to those whom it may concern) as 'hospitalization'.

"The politicians could well follow this hospital example of economy in words—such as rodomontade (now, that is a pretty word) as 'Democracy cannot function unless everyone is prepared to put aside personal and sectional interests, by one word: 'Conscription'.

"I admit that I would strongly condemn the use of the word 'hospitalization'—if I were not working in the hospital field. It is ugly, but is not uglier than 'Blitzkreig'. As it is now part of hospital service, we hospital workers will not tolerate political interference with it. I shout, defiantly, 'hospitalization'."

### Hints to Visitors

In an issue of *The Indian Hospital,* published at Madras, we found a charmingly worded set of hints to visitors. We think that any visitor would blush to disregard such courteously written gentle suggestions.

"When you visit a patient in hospital leave little children to cry at home;

wear bright clothes just come home from the dhobi;

don't shake hands or rub noses with the patient;

don't mistake the patient's bed for a chair;

seek no special favours;

keep to the visiting hours;

speak gently; and of pleasant things;

don't smuggle unpermitted delicacies into the patient's locker;

don't bore the patient with too many queries;

let the patient do the talking if able and willing;

remain where the patient can easily see your face;

but please don't remain long."

* * *

### Saving Physical Resources in Emergency

In commenting on the heroism and self-sacrifice of the medical and nursing staffs of English hospitals during air-raids, Hospital and Nursing Home Management states that "nevertheless, medical authorities have questioned whether this excessive strain would have been necessary if full use had been made of the arrangements provided to co-operate in these acute emergencies. If the summons (for mobile teams of medical men) is sent when the need first becomes apparent, it is obvious that all parties are better able to co-ordinate their activities than when the hospital staff are worn out by the strain of long continual exertion." They quote from a correspondent of *The Lancet* who advises that "The hospital staff—medical, nursing or lay—should knock off before they are compelled to by sheer fatigue, and those in charge should realize that their job is to foretell when this limit is likely to be reached and ask for help in time."

### Graduating Nurses Bring Honour to Vancouver General Hospital

The Vancouver General Hospital was exceptionally proud of this year's class of graduating nurses, who took the first three places in the provincial examinations. Clara Yee Kwong, a diminutive and very popular Chinese girl, was cheered "to the rafters" when she received a scholarship for post-graduate study at the graduation exercises. The two other girls who stood second and third respectively, were Barbara Jane May and a Japanese girl, Alice Michiyo Uyede.

* * *

### Jaw Bones from Ribs

New noses, new cheek bones, new jaws, built up for the most part from the owner's ribs, are among the achievements of plastic surgeons in Britain's hospitals to-day.

Although the heaviest air "blitz" kills or maims only a fraction of the total estimated before the Luftwaffe came, the proportion receiving facial injuries is high. Thirty years ago many of these mutilations would have been beyond remedy. To-day the plastic surgeon can virtually restore most of the features to normality.

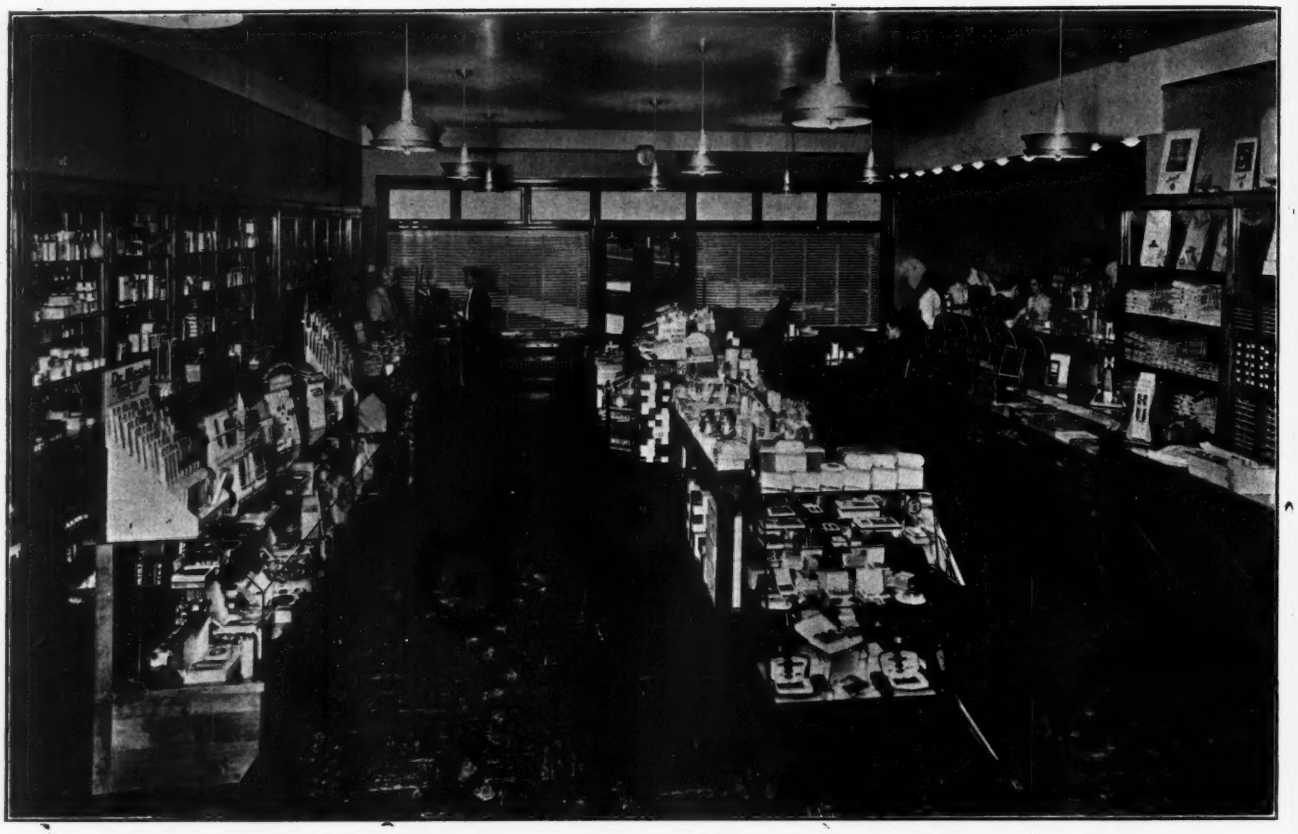
He will graft as much as a hundred square inches of skin from one part of the patient's body to another. A section of rib, six inches long, becomes a jawbone. A woman smiling to greet a friend does so thanks to the section of sciatic nerve that keeps normal a face which would have been permanently twisted by deep glass wounds.

Every week the surgeons of Britain are slowly and successfully rebuilding these features damaged by splinters and fragments of flying glass, wood and steel.

* * *

### Derivations

The word gout is derived from the French *goutte,* a drop, because it was once thought to proceed from a drop of acrid matter in the joints.



**Successful Canteen at Queen Alexandra Sanatorium, London.**

*For fifteen years the canteen at the Queen Alexandra Sanatorium, London, Ontario, under the supervision of Mr. R. W. Edwards of the Staff, has been a "going" concern. A little over a year ago it moved into a new building and now accommodates a general store, barber shop and a soda fountain, equipped to serve light lunches. Articles made by patients and ready for purchase are attractively displayed in a show case. All employees of the Canteen are ex-patients, with the exception of the soda fountain staff, and profits are distributed to the various patients' welfare services carried on in the sanatorium.*

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### Dr. R. C. Buerki Appointed Dean Of Pennsylvania Medical School

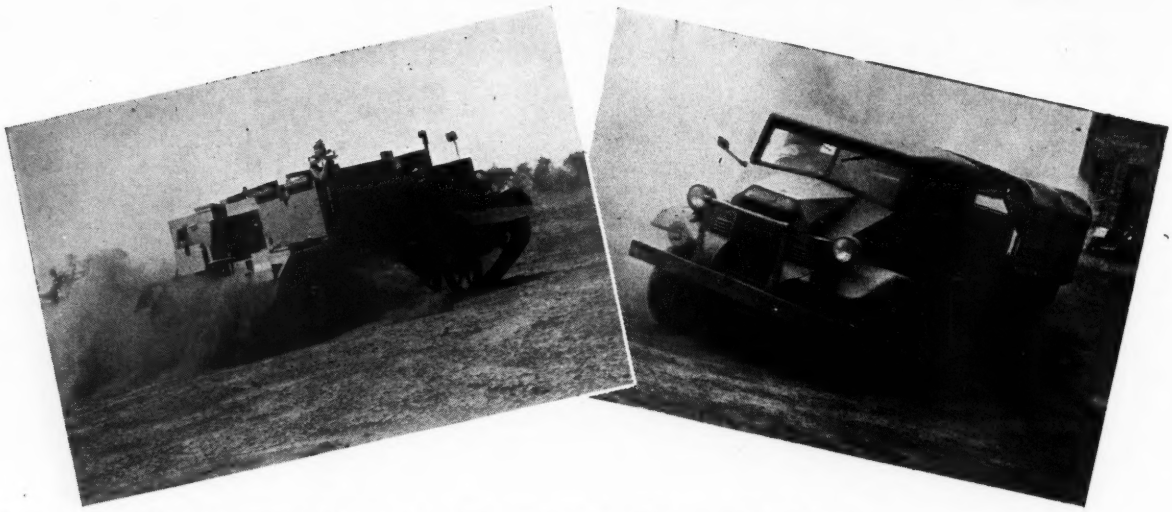
Dr. R. C. Buerki, administrator at the University of Wisconsin Hospitals, has been appointed dean of the Graduate School of Medicine and director of hospitals of the University of Pennsylvania, the appointment to begin in October. Dr. Buerki, who is well known to Canadians, is a past president of the American Hospital Association and the American College of Hospital Administrators, and is now chairman of the very successful Tri-State Hospital Assembly. The hospitals of the University of Pennsylvania, of which Dr. Buerki will have charge, include the University Hospital, the Graduate Hospital and the Orthopaedic Hospital.

### Newfoundland R.C.A.F. Hospital Named After Sir Frederick Banting

In honour of the late Sir Frederick Banting, the new R.C.A.F. hospital at Gander Lake, Newfoundland, has been named the Sir Frederick Banting Hospital. Sir Frederick visited the hospital shortly before he was killed. The 100-bed hospital, which is already in operation is equipped with operating rooms, x-ray apparatus and laboratory facilities. It is staffed by medical officers, orderlies and seven nurses of the R.C.A.F. medical services under the direction of Air Commodore R. W. Ryan, and it serves army units stationed in the vicinity as well as R.C.A.F. personnel.

### La Verendrye Hospital Opened At Fort Francis

The dedication and opening of the newly constructed hospital at Fort Francis, Ontario, which will be operated by the Sisters of Charity. Order of Grey Nuns, took place early last month. The three-storey building which will have accommodation for fifty patients was constructed at a cost of $150,000. The hospital has an x-ray department and laboratory, as well as surgical unit, case rooms and nursery. Mr. Ernest Gagnon, secretary of the St. Boniface Hospital, Manitoba, which is also under the Order of Grey Nuns, and secretary of the Manitoba Hospital Association, spoke on behalf of the Sisters at a banquet attended by many distinguished guests.



# Ontario Doctors Witness Tests of War Machines

Doctors of Ontario and their wives were shown Canadian-built war machines in action at a spectacular demonstration staged by Ford Motor Company of Canada, Limited, during the annual convention of the Ontario Medical Association in Windsor recently.

The doctors visited the great Canadian Ford plant where more than 12,000 workers are busy on production of mechanical transport for the Empire armies. Later in the day they witnessed a demonstration of various types of Ford military vehicles in action, including the Universal carriers, field artillery tractors and army trucks ranging from the speedy little 8 cwt. trucks to the huge 6-wheeled lorries. Driven by expert test drivers, the machines were put through their paces over a specially constructed proving track complete with ditches, "shell" holes and heavy sections of deep mud.

At the luncheon which preceded the tour of the plant and demonstration the guests were welcomed by Mr. Wallace R. Campbell, president of the Canadian Ford Company. He revealed that the Canadian Automobile Industry has supplied more than 115,000 vehicles for military use to Empire forces in all Empire countries and that of these, more than 75,000 units have been supplied by this company.

The accompanying photos show a Universal carrier in action, making a hairpin turn at high speed and a 15 cwt. army truck skidding around a short turn on the test track.

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## Recommends Completion of Internship Before Conferring Licence

A recommendation which would be a solution to the practice of some interns of breaking their contracts before the completion of the internship year was embodied in the annual report of the Committee on Education which was presented to the Ontario Medical Association at its Windsor convention by the Committee Chairman, Dr. Geo. A. Ramsay of London. The action of certain interns in jumping their contracts has brought considerable discredit on the intern body as a whole and calls for definite action if hospitals are to continue the use of interns.

This report reads in part:

"Your Committee in its report of 1937 dealt with this subject from various angles and went on record as to the essential need of requiring a satisfactory period of internship for either graduation or licensure.

"Under conditions, since then achieved in medical organization wherein there is a joint examination for university graduation and certification by the Medical Council of Canada, we now believe that the emphasis lies with the need of internship for final registration with the Ontario Medical Council. The reasons therefore are fully dealt with in the 1937 report. One particular feature, that of certain tendencies on the part of a small group of interns who fail to observe the validity of contract, is working to disadvantage in service to the public in operation of hospitals.

"We believe that this abuse could be very well dealt with by obtaining agreement with the Ontario College of Physicians to revert to a plan in effect some years ago, whereby the final examination for licensure was taken one year following graduation. It is our belief that the written examination as a part of the present joint examination might be considered as sufficient for graduation and temporary registration by the College, and that a more effective test would lie in the oral being deferred until after a year in hospital practice."

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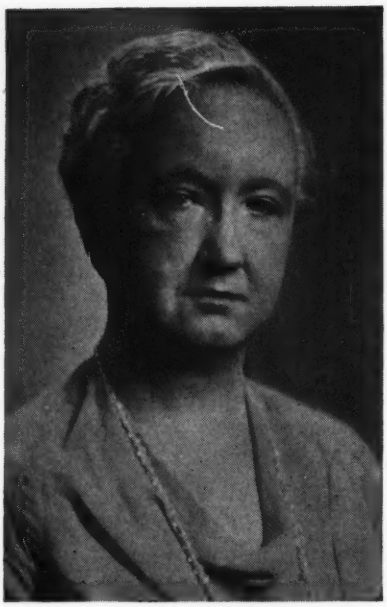
### Columbia Coast Mission Hospital Completes Addition

The new 8-bed one-storey addition to St. George's Hospital, Alert Bay, B. C., was opened recently by Rev. Alan D. Greene, superintendent of the Columbia Coast Mission. St. George's now has accommodation for 29 beds. Dr. David Ryle is medical director and Mrs. L. Lucy matron.



**Miss Jean I. Gunn Passes**

The death occurred on June 28th of Miss Jean I. Gunn, one of Canada's outstanding women and internationally known for her contributions to the profession of nursing.

Miss Gunn, who had been superintendent of nurses for the past twenty-seven years at Toronto General Hospital, was born in Belleville, Ontario, and graduated in 1905 from the Presbyterian Hospital, New York. After five years of nursing at that hospital, she spent two years doing social service work, and then went to Morrisburg, N. J., as superintendent of nurses at the Memorial Hospital. Two years later she came to Toronto to take up the position which she held at the time of her death.

Miss Gunn took an extremely active part in both Canadian and international nursing organizations. She served as president of the Canadian Nurses Association and was honoured by the vice-presidency of the International Council of Nurses. She was also Adviser in Nursing, Canadian Red Cross Society, a member of the board of the Florence Nightingale Foundation and representative of the International Council and the League of Red Cross Societies. She was, too, one of the founders of the Bedford Post-Graduate Nursing Course, London, England.

Many honours recognized the quality of her contributions to her profession. In 1925 she was awarded a Rockefeller Scholarship for hospital study in Europe. Ten years later the Order of the British Empire was conferred upon her by the Late King George and the French government honoured her with a medal. The Florence Nightingale Medal for outstanding contributions to the welfare of mankind was presented to her by the International Red Cross Committee of Geneva, and the highest honorary degree was conferred upon her by the University of Toronto.

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## R. H. P. Orde

Mr. R. H. P. Orde, O.B.E., who until his resignation only a few weeks ago was an honorary secretary of the British Hospitals Association, died on May 24th, 1941.

Mr. Orde was well known for his contributions to the voluntary hospitals system. It was largely through his efforts that the Voluntary Hospitals Commission of the British Hospitals Association ("Sankey" Commission) was set up, of which body he was honourary secretary. The hospital regionalization scheme, now developing rapidly under the Nuffield Provincial Hospitals Trust, was the result of the report of that Commission.

His first hospital post was with the London Hospital, but after a short time he became house governor at the Royal Victoria Infirmary, Newcastle-on-Tyne. In 1922 he returned to London to take up an appointment with the Medical Department of the Joint Council of St. John and the Red Cross, which was reorganized under his direction as the Central Bureau of Hospital Information. In 1929 he became honorary secretary of the British Hospitals Association. Since that time he has served on many committees, including the Committee on Hospital Standards set up by the London County Council.

### Correction

The Hamilton County Home and Chronic Disease Hospital referred to in an article on Sawdust Beds in our April issue, is located in Cincinnati, Ohio, and is not located in Hamilton, Ontario. We regret the misleading omission which caused some of our interested readers to write to Hamilton, Ontario.

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### Saskatchewan X-Ray Technicians Hold Annual Meeting

The Saskatchewan Society of X-ray Technicians held its second annual meeting at the King George Hotel, Saskatoon, on May 24th. This society now numbers eighty members and plans to meet in Moose Jaw next year.

Speakers of the day included Dr. W. S. Lindsay, Dean of the Faculty of Medicine, University of Saskatchewan, who spoke on university courses for those interested in x-ray technique; Dr. A. B. McConnell, radiologoist at Saskatoon City Hospital and Mr. Leonard P. Goudy, superintendent of the hospital; and Dr. Del Johnson, radiologist at St. Paul's Hospital, who spoke on local educational meetings.

Officers elected for the coming year are:

President, Percy Hunt, Saskatoon; vice-president, George Tokarek, Saskatoon; secretary, Miss Maleverrierre, Moose Jaw; executive member, Rev. Sister Benignus, Regina; and treasurer, George Derrick.

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### Manitoba Indian Hospital Enlarged

The Fisher River Indian hospital, 140 miles north of Winnipeg, has been enlarged from 20 to 36 beds. The hospital was opened in July, 1940, but has been so busy that increased accommodation was necessary.

## COMING CONVENTIONS

August 13-27—Institute on Hospital Administration, Chicago.
September 10-11—Canadian Hospital Council, Montreal.
September 15-19—American Hospital Association, Atlantic City.
October 8-10—Ontario Hospital Association, Royal York Hotel, Toronto.
October 20-31—Second New York Institute for Hospital Administrators, New York.

### Fifty Years of Growth

(*Continued from page* 17)

$2,500 for the heating plant. This second building was erected on the property which has since been a land mark in the City of Calgary as the location of the Holy Cross Hospital. The land had been contributed to the Sisters by the members of the Oblate Order. The new hospital was completed on November 2nd, 1892, and still forms part of the present organization, now providing quarters for the male employees of the institution. If the four Grey Nuns who came to establish the hospital in 1891 could look through the years today they would find an institution which has advanced far beyond their most hopeful dreams.

The present hospital which was completed in 1928 has a capacity for 335 patients at one time and last year the number of patients admitted to the hospital was 8,188. It is furnished with the newest and most scientific equipment available including 6 operating rooms, 3 major, 1 orthopaëdic, 1 cystoscopic and 1 minor. Care has been taken to provide for the health and comfort of nurses, graduates and students, who have their own dining room and their own residence. Since the nursing school was established there have been 592 graduates.

The Holy Cross Hospital was instituted and has since its beginning been operated by the Grey Nuns, an order founded in Montreal 200 years ago by Mother d'Youville. The Order now has institutions throughout Canada and particularly through western Canada. There is no doubt the future of the hospital will maintain and even further the accomplishments of the past.





### Essential Factors in the Internship

(*Continued from page* 30)

impressed upon him early in his training is fortunate. The physical examination is not complete unless those laboratory procedures which are applicable to the particular case are performed. Considering that at least 75 per cent of our practising physicians will find themselves later on in a locality where no technicians are available, it would appear to be a backward step to omit this important work from post-graduate training. The practising physician who is unable to do accurately complete urinalyses and blood work will find himself at a disadvantage. In addition he should be sufficiently familiar with the technique of performing all of the more common laboratory procedures which include non-protein nitrogen estimations, blood sugars, $CO_2$, combining power, the bacteriological examinations for bacteria such as tubercle bacilli, Neisserian infection and pneumococcus.

#### Three Essentials

It is a wise intern who realizes

1. That post-graduate training is an opportunity the like of which in all probability he will not have the privilege of enjoying again.

2. That a proper amount of time should be allocated to sport and recreation. Social engagements away from the hospital atmosphere provide relaxation and benefit is derived by friendships with persons outside the medical profession. An appreciation of good music should be cultivated.

3. That a proper amount of rest is essential to good health and good thinking.

The whole problem of post-graduate training or internship in our hospitals should be correlated with the medical training provided by our universities. Give any intern the opportunity of a sound practical clinical training under good medical supervision with the minimum number of regulations, for his guidance as to "off" and "on" duty and he may be relied upon to adequately protect his health. We may have no fear of "Making Jack a Dull Boy" by providing clinical experience in abundance but rather a well trained young doctor who will be a credit to himself and his profession.

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The Hotel Dieu of Montreal plans to start construction on a new 8-storey wing this month. It is anticipated that the wing will be completed early in 1942 and will be dedicated to Jerome Leroyer during tercenteniary celebrations of that year.

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Nothing is so strong as gentleness; nothing is so gentle as real strength.
—*St. Francis de Sales.*

## Price Trends

***(On basis 1926 = 100)***

| | Yearly Average 1940 | April 1940 | March 1941 | April 1941 |
|---|---|---|---|---|
| Building and Construction Materials | 95.6 | 95.1 | 100.6 | 100.7 |
| Consumers' Goods (Wholesale) | 83.4 | 82.4 | 86.2 | 87.0 |
| | ***(On basis 1932-1939 = 100)*** | | | |
| Cost of Living | 105.6 | 104.6 | 108.2 | 108.6 |

## *Index to Advertisers*

### JULY, 1941